Volume 26, Number 2
Pages 99–312
January 16, 2001

Matt Blunt

Secretary of State

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

Secretary of State
Matt Blunt

Administrative Rules Division
James C. Kirkpatrick State Information Center
600 W. Main
Jefferson City, MO 65101
(573) 751-4015

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO
Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
P.O. Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the internet. The Register address is http://mosl.sos.state.mo.us/moreg/moreg.htm and the CSR is http://mosl.sos.state.mo.us/csr/csr.htm. These web sites contain rulemakings and regulations as they appear in the Registers and CSR. These web sites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo 2000. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, P.O. Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

January 16, 2001 Vol. 26 No. 2 **Pages 99–312**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication	Code Publication	Code Effective
Oct. 2, 2000	**Nov. 1, 2000**	Nov. 30, 2000	Dec. 30, 2000
Oct. 16, 2000	**Nov. 15, 2000**	Nov. 30, 2000	Dec. 30, 2000
Nov. 1, 2000	**Dec. 1, 2000**	Dec. 31, 2000	Jan. 30, 2001
Nov. 15, 2000	**Dec. 15, 2000**	Dec. 31, 2000	Jan. 30, 2001
Dec. 1, 2000	**Jan. 2, 2001**	Jan. 29, 2001	Feb. 28, 2001
Dec. 15, 2000	**Jan. 16, 2001**	Jan. 29, 2001	Feb. 28, 2001
Dec. 29, 2000	**Feb. 1, 2001**	Feb. 28, 2001	March 30, 2001
Jan. 16, 2001	**Feb. 15, 2001**	Feb. 28, 2001	March 30, 2001
Feb. 1, 2001	**March 1, 2001**	March 31, 2001	April 30, 2001
Feb. 15, 2001	**March 15, 2001**	March 31, 2001	April 30, 2001
March 1, 2001	**April 2, 2001**	April 30, 2001	May 30, 2001
March 15, 2001	**April 16, 2001**	April 30, 2001	May 30, 2001
March 30, 2001	**May 1, 2001**	May 31, 2001	June 30, 2001
April 13, 2001	**May 15, 2001**	May 31, 2001	June 30, 2001
May 1, 2001	**June 1, 2001**	June 30, 2001	July 30, 2001
May 15, 2001	**June 15, 2001**	June 30, 2001	July 30, 2001
June 1, 2001	**July 2, 2001**	July 31, 2001	August 30, 2001
June 15, 2001	**July 16, 2001**	July 31, 2001	August 30, 2001

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule.

Missouri Depository Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Depository Documents Law (section 181.100, RSMo 2000), are available in the listed depository libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2756

Eden Theological Seminary/
Webster University
Eden/Webster Library
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University
Washington University Law Library
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6484

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300

Maryville University Library
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

St. Charles City-County Library
Middendorf-Kredell Branch
2750 Hwy K
O'Fallon, MO 63366-7859
(314) 978-7997

Truman State University
Pickler Memorial Library
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 204 South Union St.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

Charles F. Curry Library
William Jewell College
500 College Hill
Liberty, MO 64068-1896
(816) 781-7700

Ward Edwards Library
Central Missouri State University
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
311 East 12th St.
Kansas City, MO 64106-2454
(816) 701-3400

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

University of Missouri-Kansas City
Miller Nichols Library
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-1281

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

River Bluffs Regional Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Missouri Western State College
Hearnes Learning Resources Ctr.
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948

Missouri Southern State College
Spiva Library
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9770

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3075

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
104 Ellis Library
Columbia, MO 65211-5149
(573) 882-6733

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65201-7298
(573) 882-7083

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Central Methodist College
Smiley Memorial Library
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6292

Library
University of Missouri-Rolla
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Kinderhook Regional Library
135 Harwood Ave.
Lebanon, MO 65536-3017
(417) 532-2148

ESTEP Library
Southwest Baptist University
1601 S. Springfield Street
Bolivar, MO 65613-2597
(417) 326-5281

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411

West Plains Campus Library
Southwest Missouri State University
123 N. Minnesota
West Plains, MO 65775-3414
(417) 256-9865

Springfield-Greene County Library
PO Box 737, 397 E. Central
Springfield, MO 65801-0760
(417) 869-4621

Meyer Library
Southwest Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 26, *Missouri Register*, page 27. The approved short form of citation is 26 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than 180 calendar days or 30 legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 1—OFFICE OF ADMINISTRATION
Division 10—Commissioner of Administration
Chapter 15—Cafeteria Plan

EMERGENCY AMENDMENT

1 CSR 10-15.010 Cafeteria Plan. The Office of Administration is amending the rule on the cafeteria plan by amending section (1), Appendix A, section 2.01, section 3.01, section 3.02, section 3.04, section 3.06, section 3.07, section 4.01, section 6.01, section 8.01 and by adding a new section 3.08; and changing Appendix B, section 4.01; Appendix C, section 3.02, section 3.03, section 4.05, section 6.03, section 7.02 and by adding section 6.04 and section 6.05.

PURPOSE: This rule is being amended for the following reasons: (1) to comply with new federal rules regarding changes in family-status and employment-status for health and life insurance benefits, (2) to provide for changes in the cost of health plan coverage (3) to provide for changes in the election of Dependent Care, (4) to amend the eligibility of a returning employee after separation of service and (5) to delete all references to group-term life insurance benefits and their eligibility under the provisions of the Cafeteria Plan.

*EMERGENCY STATEMENT: This emergency amendment is necessary to preserve a compelling government interest that requires an early effective date. Without this amendment, the Missouri State Employees' Cafeteria Plan would not be in compliance with the **Internal Revenue Code**. Therefore, this employee benefit plan, with $54,600,000 in contributions (CY 2000), would be at risk of being retroactively eliminated. Any disruption in the application of this plan would create serious tax implications for the plan's 27,800 participants, since taxes would be owed on the amount contributed to the plan while authorization was suspended. Therefore, it is of considerable compelling government interest that the Missouri Cafeteria Plan not be put in jeopardy of being eliminated and thus depriving the 27,800 employees and their families of this benefit. This amendment also follows procedures best calculated to assure fairness to all interested parties under the circumstances. This emergency amendment is limited in scope to the circumstances creating this emergency and complies with the protection extended by the **Missouri** and **United States Constitutions**. Emergency amendment filed December 11, 2000; effective January 1, 2001; expires June 29, 2001.*

(1) The cafeteria plan for state employees, authorized by section 33.103, RSMo shall contain the following items:

(D) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any plan or program *[of group term life insurance covering the employee's life, which plan or program is available to the employee by reason of his/her status as an employee;*

(E) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any plan or program] which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of his/her status as an employee;

*[(F)]***(E)** A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any plan or program which provides vision care benefits or vision care insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of his/her status as an employee; and

*[(G)]***(F)** A provision authorizing a participating employee to reduce his/her future compensation for purposes of participation in the cafeteria plan.

*AUTHORITY: section 33.103, RSMo [Supp. 1999] **2000**. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 11, 2000, effective Jan. 1, 2001, expires June 29, 2001.*

APPENDIX A
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN

The State of Missouri through the Office of Administration hereby amends and restates the Missouri State Employees' Cafeteria Plan (hereinafter called the MSECP) effective January 1, *[2000]* **2001**. *[The MSECP shall be in the form of a trust established by the State of Missouri for public employees of the state who participate in the MSECP.]* The provisions of the MSECP, as set forth in this document and the attendant documents for the Missouri State Employees' Dependent Care Assistance Plan (Appendix B, hereinafter called the MSEDCAP) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C, hereinafter called the MSEFMBP), shall be applicable to each employee of the State of Missouri who elects to participate in the MSECP beginning with Plan Year *[2000]* **2001**.

ARTICLE TWO
STATEMENT OF PURPOSE

2.01 **This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the *Internal Revenue Code* of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.** The purpose of the MSECP is to provide to participants the tax savings opportunities permissible under Section 125 of the *Internal Revenue Code*.

ARTICLE THREE
ELIGIBILITY AND PARTICIPATION

3.01 The MSECP does not apply to any individual who terminated employment with the employer prior to the effective date of this amended and restated MSECP (January 1, *[2000]* **2001**) unless such individual becomes reemployed by the employer on or after such effective date.

3.02 Any employee who is on the payroll of the employer as of the effective date is eligible to become a participant at the beginning of each Plan Year. Any eligible employee, except any employee subject to the provisions of the MSECP, section 3.03, who chooses not to become a participant at the beginning of each Plan Year will not again become eligible for participation in the MSECP until the beginning of the next Plan Year*, [unless the employee experiences a change in family status]* **except** as provided under the MSECP, section 3.07*[, whereby the employee may enroll within sixty (60) days of the occurrence of the allowable change in family status]*.

3.04 Subject to the provisions of the MSECP, section 3.05, an eligible employee shall become a participant for any Plan Year by specifying on the appropriate election form or in an alternate prescribed manner, agreement to and authorization for the reduction of the participant's compensation by a permissible amount for credit to the participant's account as maintained by the Plan Administrator. For purposes of the first sentence of this paragraph, the term "permissible amount" (unless and until subsequently changed by appropriate action of the Office of Administration and notice of such change is provided to all participants) means an amount(s) determined by the participant which is (are):

(a) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Medical Insurance benefit described in the MSECP, section 4.01(a);

(b) not more than five thousand dollars ($5,000) in the case of the Flexible Medical Benefits benefit described in the MSECP, section 4.01(b);

(c) not more than five thousand dollars ($5,000) in the case of the Dependent Care Assistance benefit described in the MSECP, section 4.01(c);

(d) not more than the expected total cost or premium during the Plan Year *[for coverage not to exceed applicable Internal Revenue Service limits in the case of the State-Sponsored Group Term Life Insurance benefit described in the MSECP, section 4.01(d);*

(e) not more than the expected total cost or premium during the Plan Year] in the case of the State-Sponsored Dental Insurance benefit described in the MSECP, section 4.01*[(e)]* **(d);**

*[(f)]***(e)** not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Vision Care Insurance benefit described in the MSECP, section 4.01**(e).***[(f); and**

(g) not more than the total of maximum amounts set forth previously in the case of the benefit described in the MSECP, section 4.01(g)] In the event of any change in the permissible amount, the resulting new permissible amount must be nondiscriminatory (as defined in Section 125 of the *Internal Revenue Code*) in its application to participants. In the case of the insurance benefits described in the MSECP, sections 4.01(a), 4.01(d), **and** 4.01(e) *[and 4.01(f)],* the permissible amount elected by the employee must be consistent with or will automatically be changed to reflect the actual rate in effect at the start of the coverage period.

3.06 *[Beginning with Plan Year 1999, a]* **A**ny employee duly enrolled and participating in one or more of the insurance benefits described in the MSECP, sections 4.01(a), 4.01(d), **or** 4.01(e) *[or 4.01(f)],* shall be considered to have re-enrolled and to have submitted the required authorization to continue participation in the same benefit(s) for the subsequent Plan Year at an amount equal to the total expected annual cost or premium based on the rate in effect as of January 1 of that subsequent Plan Year. A participant who does not wish to continue an insurance benefit under the Cafeteria Plan for a subsequent Plan Year must so specify on the appropriate election form or in an alternate prescribed manner prior to the start of the subsequent Plan Year.

3.07 Permitted Election Changes.

(a) Following the commencement of any Plan Year for which an employee elects to participate in the MSECP, the authorization filed with the Plan Administrator for such Plan Year may neither be changed nor revoked except as provided in this section. An employee may

revoke an election during a period of coverage and make a new election for the remainder of the relevant coverage period only as provided in paragraphs (b) through *[(i)]* **(h)** of this section.

(b) Special enrollment rights. An employee may revoke an election for a benefit described under Article Four, section 4.01(a), *[4.01(b),]* **4.01(d), or** 4.01(e)*[, or 4.01(f)]* and make a new election that corresponds with the special enrollment rights provided in *Internal Revenue Code* Section 9801(f) (HIPPA), whether or not the change in election is permitted under paragraph (c) of this section.

(c) Changes in status *[for benefits described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), and 4.01(f)]*.

1. An employee may revoke an election *[for a benefit described under Article Four, section 4.01(a), 4.01(d), 4.01(e), or 4.01(f)]* and make a new election for the remaining portion of the period if, under the facts and circumstances—

(i) *[Following the commencement of any Plan Year a]***A** change in status occurs; and

(ii) The election change satisfies the consistency requirement in paragraph (c)(3) of this section *[(consistency rule for accident or health coverage), (c)(4) of this section (consistency rule for Flexible Medical Benefits) or (c)(5) of this section (consistency rule for group-term life insurance coverage)]*.

2. Change in status events. The following events are changes in status for purposes of this paragraph (c)—

(i) Legal marital status. Events that change an employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(ii) Number of dependents. Events that change an employee's number of dependents (as defined in *Internal Revenue Code* Section 152), including birth, adoption, placement for adoption (as defined in regulations under *Internal Revenue Code* Section 9801), or death of a dependent**, or in the case of Dependent Care, a change in the number of qualifying individuals as defined in *Internal Revenue Code* Section 21 (b)(1);**

(iii) Employment status. *[A termination or commencement of employment by the employee, spouse, or dependent;*

(iv) Work schedule. A reduction or increase in hours of employment by the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence;] **Any of the following events that change the employment status of the employee, spouse, or dependent is considered a change in status. A termination, commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence of more than thirty (30) days, change in worksite, or any other employment status change that affects eligibility under this plan or employee benefit plan of the employer of the spouse or dependent;**

*[(v)]***(iv)** Dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage; and

*[(vi)]***(v)** Residence *[or worksite]*. A change in the place of residence *[or work]* of the employee, spouse, or dependent.

3. Consistency rule *[for accident or health coverage]*—

(i) General rule.

[(A)] An employee's revocation of a Cafeteria Plan election during a period of coverage and new election for the remaining portion of the period (referred to as an "election change") is consistent with a change in status if, and only if—

*[(1)]***(A)** The change in status results in the employee, spouse, or dependent gaining or losing eligibility for *[accident or health]* coverage under either the Cafeteria Plan or *[an accident or health]* **a** plan of the spouse's or dependent's employer; and

*[(2)]***(B)** The election change corresponds with that gain or loss of coverage.

(ii) If the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election under the cafeteria plan to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel accident or health coverage for any other dependent, for the employee, or for the employee's spouse fails to correspond with that change in status.

In addition, if an employee, spouse, or dependent gains eligibility for coverage under a plan provided by the employer of the spouse or dependent as a result of a change in marital status or a change in employment status, the employee may cease or decrease coverage for that individual only if coverage for that individual becomes applicable or is increased under that employer's plan.

*[(B)]***(iii)** A change in status results in an employee, spouse, or dependent gaining (or losing) eligibility for coverage under a plan only if the individual becomes eligible (or ineligible) to participate in the plan. An individual is considered to gain or lose eligibility for coverage if the individual becomes eligible (or ineligible) for a particular benefit package option under a plan (e.g., a change in status results in an individual becoming eligible for a managed care option or an indemnity option). If, as a result of a change in status, the individual gains eligibility for elective coverage under a plan of the spouse's or dependent's employer, the consistency rule of this paragraph (c)(3)(i) is satisfied only if the individual elects the coverage under the spouse's or dependent's employer.

*[(ii)]***(iv)** Exception for COBRA. Notwithstanding paragraph (c)(3)(i) of this section, if the employee, spouse, or dependent becomes eligible for continuation coverage under *[the employer's group health plan as provided in section 4980B]* **any of the employer's health plans described in sections 4.01(a), 4.01(d), or 4.01(e) as provided under COBRA** or any similar state law, the employee may elect to increase payments under the Cafeteria Plan in order to pay for the continuation coverage.

[4. Consistency rule for flexible medical benefits.] **(v)** Except as provided in this paragraph the provisions of paragraph (c) apply to an election change under a benefit described under Article 4.01(b). A participant may reduce an election for a benefit described under 4.01(b) **due to a change in status** if and only if the employee's legal martial status changes due to death, divorce, annulment, or legal separation, or there is a reduction in the number of dependents of the employee (as defined in section 152 of the *Internal Revenue Code*) due to death *[, or the commencement of a leave under the Family and Medical Leave Act.*

5. Consistency rule for group-term life insurance coverage. Except as provided in this paragraph (c)(5), the provisions of paragraph (c)(3)(i) of this section apply to group-term life insurance coverage. In the case of marriage, birth, adoption, or placement for adoption, an employee may make an election change to increase (but not to reduce) the amount of the employee's life insurance coverage. In the case of divorce, legal separation, annulment, or death of a

spouse or dependent, an employee may make an election change to reduce (but not to increase) the amount of the employee's life insurance coverage].

(d) Judgment, decree, or order. This paragraph (d) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of the Employee Retirement Income Security Act of 1974) that requires accident or health coverage for an employee's child. Notwithstanding the provisions of paragraph (c) of this section, an employee may—

1. Make an election change to a benefit described under sections 4.01(a), 4.01(b), **4.01(d), or** 4.01(e) *[, or 4.01(f)]* to provide coverage for the child if the order requires coverage under the employee's plan; or

2. Make an election change to a benefit described under sections 4.01(a), **4.01(b), 4.01(d), or** 4.01(e)*[, or 4.01(f)]* to cancel coverage for the child if the order requires the former spouse to provide coverage.

(e) Entitlement to Medicare or Medicaid. If an employee, spouse, or dependent becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), an employee may make an election change to a benefit described under sections 4.01(a), **4.01(d), or** 4.01(e) *[, or 4.01(f)]* to cancel coverage of that employee, spouse, or dependent under the accident or health plan. **In addition, if an employee, spouse, or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, an employee may make an election change to commence or increase coverage under a benefit described under sections 4.01(a), 4.01(d), or 4.01(e).**

[(f) Election Changes for Dependent Care. An employee may revoke an election for a benefit described under Article Four, section 4.01(c) and make a new election for the remaining portion of the period if, under the facts and circumstances a change in status occurs; and the revocation and new election are consistent with and on account of the change in status. Examples of changes in status are:

1. Legal martial status. Events that change an employee's legal martial status, including marriage, death of spouse, divorce, legal separation, or annulment;

2. Number of dependents. Events that change an employee's number of dependents (as defined in section 152), including birth, adoption, placement for adoption (as defined in regulations under section 9801), or death of a dependent; or

3. Employment status. A termination or commencement of employment by the employee or spouse or the commencement of or a return from an unpaid leave of absence.]

(f) Coverage or cost changes. Changes allowed under this section are not applicable to Flexible Medical Benefits as described in section 4.01(b). Therefore, no changes to an election for Flexible Medical Benefits is allowed due to events described in this section (f).

1. Cost changes. A participant's election for a benefit described under Article 4.01(a), 4.01(d), or 4.01(e) will automatically be changed to reflect a change in the cost of coverage. Alternatively, if the premium amount significantly increases a participant may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

2. Coverage changes. If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may revoke their election under the plan and may make a new election on a prospective basis for coverage under another benefit package option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primary care physician would not be a significant curtailment because it does not affect participants in general.

Addition (or elimination) of benefit package option providing similar coverage. If during a period of coverage the plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

3. Change in coverage of spouse or dependent under other employer's plan. An employee may make a prospective election change to a benefit described under sections 4.01(a), 4.01(d), and 4.01(e) that is on account of and corresponds with an election made under the plan of the spouse's, former spouse's or dependent's employer if the period of coverage under the cafeteria plan or qualified benefits plan of the spouse's, former spouse's, or dependent's employer only allows elections for periods of coverage different than the Plan Year for the MSECP.

[(g) Significant coverage or cost changes.

1. Employer's plan. A participant's election for a benefit described under Article 4.01(a), 4.01(e), or 4.01(f) will automatically be changed to reflect a change in the cost of coverage attributable to an independent third party provider. Alternatively, if the premium amount significantly increases or coverage is significantly curtailed a participant may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

2. A participant may revoke an existing election for a benefit described in section 4.01(a), 4.01(e), or 4.01(f) and make a new election due to a significant change in the health coverage of the participant or the participant's spouse attributable to the spouse's employment. A participant may increase an existing election for a benefit described in section 4.01(b) due to a significant change in the health coverage of the participant or the participant's spouse attributable to the spouse's employment. Any change must be consistent with and on account of the change in health coverage attributable to the spouse's employment.]

[(h)] **(g)** Special requirements concerning the Family and Medical Leave Act.

An employee taking FMLA leave may revoke an existing election *[of a benefit described under 4.01(a), 4.01(b), 4.01(e), or 4.01(f)]* for the remaining portion of the coverage period. Upon returning from FMLA leave, an employee may choose to be reinstated in any benefit described under this plan if such coverage was terminated during the FMLA leave (either by revocation or nonpayment of premiums). Such reinstatement will be on the same terms as prior to taking FMLA leave. However, the employee has no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year. In addition to the rights granted under FMLA, such an employee has the right to revoke or change elections *[(e.g., because of changes in status or*

significant cost or coverage changes imposed by a third-party provider)] under the same terms and conditions as are available to employees participating in the Cafeteria Plan who are not on FMLA leave.

If an employee's coverage under a benefit described in section 4.01(b) or 4.01(c) terminates while the employee is on FMLA leave, the employee is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If that employee subsequently elects to be reinstated in a benefit previously terminated upon return from FMLA leave for the remainder of the Plan Year, the employee may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. Further, the employee is not entitled to greater benefits relative to premiums paid than an employee who has been continuously working during the Plan Year. Therefore, if an employee elects to be reinstated in a benefit described above upon return from FMLA leave, the employee's coverage for the remainder of the Plan Year is equal to the employee's election for the 12-month period of coverage (or such shorter period as provided under section 3.03 or this section 3.07), prorated for the period during the FMLA leave for which no premiums were paid, and reduced by prior reimbursements.

[An employee on FMLA leave has the right to revoke or change elections (e.g., because of changes in family status) under the same terms and conditions that apply to employees participating in the Cafeteria Plan who are not on FMLA leave.]

[(i)] **(h)** Effective date of election changes.

Any increase in the election amount designated by a participant made due to a change in status may include only those expenses which the participant expects to incur at a time during the period of coverage subsequent to the effective date of the increase. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(b) or 4.01(c) shall be effective with the first day of the month coincident with or next following the Plan Administrator's receipt and approval of written notification of the new election. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(a), 4.01(d), **or** 4.01(e)*[, or 4.01(f)]* shall be effective with the first required premium payment after the event. *[Any provider initiated increase in the premium for a program described in the Plan document under Article Four, section 4.01(d) may be added to the participant's election amount only during the first month that the premium increase becomes effective and only to the extent as allowed under applicable Internal Revenue Service regulations.]*

3.08 If participation terminates due to a separation of service and the individual returns to eligible employment within thirty (30) days in the same Plan Year, then the participant's election will be reinstated as it was immediately prior to the separation of service. If participation terminates due to a separation of service and the individual returns to eligible employment after thirty (30) days in the same Plan Year, then the participant may make a new election for the remainder of the Plan Year. If salary reduction contributions were not made during the separation of service, the participant will not be able to be reimbursed for expenses incurred under benefits described under sections 4.01(b) and 4.01(c) during the separation.

ARTICLE FOUR
AVAILABLE SELECTION OF BENEFITS

4.01 In general, employees may choose to participate in any one or more of the following benefit categories offered under the MSECP:

(a) State-Sponsored Medical Insurance—This benefit category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides medical benefits or health insurance to or on behalf of any employee or spouse or dependent in the event of illness or personal injury to the employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid and is not duplicative of any other plan provided by the MCHCP. This article shall expressly include any Health Maintenance Organization (HMO) to which the employer makes a contribution on behalf of a participant;

(b) Flexible Medical Benefits—This benefit category provides for payment to the participant of the cost of medical care for the participant or spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEFMBP (Appendix C), established in conjunction with the MSECP;

(c) Dependent Care Assistance—This benefit category provides for payment to the participant of employment-related expenses for the care of the spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEDCAP (Appendix B) established concurrently with the MSECP;

[(d) State-Sponsored Group Term Life Insurance—This benefit category provides for the direct payment to the insurance provider for the participant's share of the cost or premium for coverage under any plan or program which provides group term life insurance covering the participant's life, which plan or program is available to the employee by reason of status as an employee;]

[(e)] **(d)** State-Sponsored Dental Insurance—This benefit category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid and is not duplicative of any other plan provided by the MCHCP;

*[(f)]***(e)** State-Sponsored Vision Care Insurance—This benefit category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides vision care benefits or vision care insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid and is not duplicative of any other plan provided by the MCHCP; and

*[(g)]***(f)** Cash.

ARTICLE SIX
CONTRIBUTIONS TO PARTICIPANT ACCOUNTS

6.01 Except as provided in the MSEFMBP, section *[3.02, 4.04,]* 6.03 or Article VII, contributions to the account of each participant shall be made only by the employer and shall be made as follows: On the participant's regular pay date during each Plan Year, the employer shall cause to be contributed for credit to the account of said participant an amount equal to the sum of the permissible amounts elected by the participant for all benefits selected for the Plan Year divided by the number of the participant's regular pay dates in the Plan Year subsequent to the participant's effective date of participation.

ARTICLE EIGHT
MISCELLANEOUS

8.01 No participant shall have any right to or interest in any assets of the MSECP upon termination or otherwise except as provided under the MSECP, and then only to the extent of the benefits payable under the MSECP to such participant. All payments of benefits provided under the MSECP shall be made solely out of the assets of the *[MSECP]* **employer.**

APPENDIX B
MISSOURI STATE EMPLOYEES' DEPENDENT CARE ASSISTANCE PLAN

ARTICLE FOUR
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSEDCAP unless the total assistance amount, including all other amounts paid to the participant for Dependent Care Assistance during the same Plan Year, does not exceed the lesser of: (a) five thousand dollars ($5000) (twenty-five hundred dollars ($2500) in the case of a married individual filing a separate return), or (b) the wages, salaries and other employee compensation of the participant if unmarried or if the participant is married does not exceed the lesser of such employee compensation of the participant or that of the participant's spouse. For purposes of this paragraph, employee compensation shall not include the total of the permissible amounts selected under the related MSECP. For each month during which a spouse is a full-time student or incapable of independent self-care, said spouse shall be deemed to be gainfully employed and to have employee compensation of two hundred dollars ($200) if there is only one (1) child or dependent and four hundred dollars ($400) if there are two (2) or more children or dependents. A spouse is a student only if during each **of** five (5) calendar months during the Plan year said spouse is a full-time student at an education organization described in *Internal Revenue Code* Section 170(b)(1)(A)(ii).

APPENDIX C
MISSOURI STATE EMPLOYEES' FLEXIBLE MEDICAL BENEFITS PLAN

ARTICLE THREE
ELIGIBILITY

3.02 Participants who elect to participate in this MSEFMBP shall elect to participate for the full Plan Year. Participants may arrange to have contributions made to the Plan as specified in the MSECP, section 6.01*[.]***,** so long as the participant remains an employee of the employer. *[Upon termination of employment with the employer, payment of claims shall cease if required contributions are not received by the date the next required contribution is due.]* **Participation and coverage shall cease upon separation of service as of the last day of the month in which the last contribution was received.**

3.03 No participant in this MSEFMBP may modify or revoke an election with respect to the Plan Year, except under the conditions specified in MSECP, section *[3.07]***3.07**. *[In addition, no participant may decrease the amount elected during a Plan Year except for a change due to the death of a spouse or dependent of the participant, divorce or legal separation, or for the participant taking a FMLA leave.]* In no case may a decrease in the amount of election result in a return of contributions to the participant.

ARTICLE FOUR
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.05 Payments **to participants** shall be suspended whenever the designated contribution amount is not received by the time the next required payment is due. Payments will resume when the required contribution amounts are paid in full.

ARTICLE SIX
CONTINUATION COVERAGE

6.03 A premium may be charged to the participant, spouse or dependent, as the case may be, for any period of continuation coverage equal to not more than one hundred two percent (102%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents. Any additional premium amount in excess of one hundred percent (100%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents, shall not be credited to the participant's account and shall be treated as an additional administrative charge. Continuation coverage will not extend beyond the end of the current plan year. However, coverage may terminate earlier if:

(a) The employer ceases to provide any medical reimbursement plans to any *[employer]* **employee**;

(b) The premiums described above are not paid within thirty (30) days of their due date; or

(c) A party electing continuation coverage becomes covered under another group health plan or entitled to Medicare benefits.

6.04 Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the MSECP.

6.05 Continuation coverage shall be provided in accordance with the requirements of Section 42 U.S.C. 300bb, all of which requirements are incorporated herein by reference.

ARTICLE SEVEN
FAMILY AND MEDICAL LEAVE

7.02 An employee who continues coverage while on FMLA leave may choose from one or more of the following payment options. These options are referred to in this section as pre-pay, pay-as-you-go and catch-up. The catch-up option is only available while the employee is on an unpaid FMLA leave.

(a) Pre-pay.

(1) Under the pre-pay option, an employee may pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period.

(2) Contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any taxable compensation.

(3) Contributions under the pre-pay option may also be made on an after-tax basis.

(b) Pay-as-you-go.

(1) Under the pay-as-you-go option, employees may pay their premium payments on the same schedule as payments would be made if the employee were not on leave or under any other payment schedule permitted by the Labor Regulations at 29 CFR 825.210(c) (i.e., on the same schedule as payments are made under the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272; under the employer's existing rules for payment by employees on leave without pay; or under any other system voluntarily agreed to between the employer and the employee that is not inconsistent with this section or with 29 CFR 825.210(c)).

(2) Contributions under the pay-as-you-go option may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due the employee during the leave period, and provided that all cafeteria plan requirements are satisfied.

(3) Coverage under *[a benefit described in section 4.01(b)]***the MSEFMBP** will be terminated for any employee who fails to make required premium payments while on FMLA leave.

(c) Catch-up.

(1) An employee on an unpaid FMLA leave may elect to use the catch-up option to pay premiums advanced on his or her behalf by the state during the FMLA leave. The state and the employee must agree in advance of the coverage period that: the employee elects to continue coverage while on unpaid FMLA leave; the state will assume responsibility for advancing payment of the premiums on the employee's behalf during the FMLA leave; and these advance amounts must be paid by the employee when the employee returns from FMLA leave.

(2) Contributions under the catch-up option may be made on a pre-tax salary reduction basis when the employee returns from FMLA leave from any available taxable compensation. These contributions will not be included in the employee's gross income, provided that all Cafeteria Plan requirements are satisfied.

(3) Contributions under the catch-up option may also be made on an after-tax basis.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 200—State Board of Nursing
Chapter 4—General Rules

EMERGENCY AMENDMENT

4 CSR 200-4.010 Fees. The board is amending subsection (1)(J).

PURPOSE: The purpose of this emergency amendment is to increase fees.

EMERGENCY STATEMENT: Pursuant to 335.036.2., RSMo 1994, "The board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter." A compelling governmental interest exists, as this emergency amendment is necessary to cover operating costs. The board has experienced a dramatic shortfall of 1.9 million dollars in the nursing fund. This shortfall has necessitated that the board secure a loan until it can make up the shortfall by increasing revenue to cover its operating expenses which must be repaid with interest by the end of fiscal year 2001. Although the board anticipates that it will be able to repay the loan by the end of fiscal year 2001, without the immediate fee increase requested herein the board will experience another shortfall in fiscal year 2002 and beyond. This emergency amendment increases the cost to renew a RN license from $60 to $100 and the cost to renew a LPN license from $52 to $92. Ten dollars ($10) of the RN fee and two dollars ($2) of the LPN fee is for the nursing student loan fund administered by the Missouri Department of Health as provided by statute 315.221, RSMo. There are four factors that have created a depletion of the Board of Nursing's fund. These are:

1. A review of the revenue and expenditures for the past 6 years identify that there has been an increase of costs and a decrease in revenue. The number of new licensure applicants decreased 16% from FY1999 to FY2000. This is higher than the national average of a 6% annual decrease. The number of LPN decreased from 23,683 to 21,603 from FY1999 to FY2000. The board traditionally has a 1 1/2 to 2% increase in licensees each year. Because of the unplanned significant decrease in the number of licensees and number of applicants, actual revenue did not reach the projected revenue.

2. The current formula that is used to determine the board's portion of cost of the division and department averages 30% based on the 3-year licensure numbers. The major expenditures of the division to upgrade the licensure system, implement optical imaging, and complete a continuing education study these past two years have created significant costs for the board; approximately $387,600.

3. The board's costs have increased the past three years due to increase in number of complaints and 3-year statute limitation on completion of cases.

4. The fee structure of the board has not changed since 1993.

*The board finds that an immediate danger to the public health, safety and welfare exists because if this emergency amendment is not enacted, the Board of Nursing will not be able to operate and carry out their duties to protect the public. The board has followed procedures calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions**. The board has limited the scope of the emergency amendment to the circumstances creating the emergency. This emergency amendment was filed on December 15, 2000, shall be effective January 1, 2001 and shall expire on June 29, 2001.*

(1) The following fees are established by the State Board of Nursing:

(J) Biennial Renewal Fee—

1. RN *[$ 60.00]* **$ 100.00**;
2. LPN *[$ 52.00]* **$ 92.00**;

3. License renewal for a professional nurse shall be biennial; occurring on odd-numbered years and the license shall expire on April 30 of each odd-numbered year beginning with the 1997-1999 renewal period. License renewal for a practical nurse shall be biennial; occurring on even-numbered years and the license shall expire on May 31 of each even-numbered year beginning with the 1998-2000 renewal period. Renewal shall be for a twenty-four (24)-month period except in instances when renewal for a greater or lesser number of months is caused by acts or policies of the Missouri State Board of Nursing. Renewal applications shall be mailed every even-numbered year by the Missouri State Board of Nursing to all LPNs currently licensed and every odd-numbered year to all RNs currently licensed;

4. A renewal fee of *[sixty dollars ($60)]* **one hundred dollars ($100)** every other year for an RN effective with the 2001–2003 renewal period and *[fifty-two dollars ($52)]* **ninety-two dollars ($92.00)** every other year for an LPN effective *[with the 2000–2002 renewal period]* **January 1, 2001** shall be accepted by the Missouri State Board of Nursing only if accompanied by an appropriately completed renewal application; and

5. All fees established for licensure or licensure renewal of nurses incorporate an educational surcharge in the amount of one dollar ($1) per year for practical nurses and five dollars ($5) per year for professional nurses. These funds are deposited in the professional and practical nursing student loan and nurse repayment fund;

*AUTHORITY: sections 335.036 and 335.046, RSMo **[1999] 2000**. Emergency rule filed Aug. 13, 1981, effective Aug. 23, 1981, expired Dec. 11, 1981. Original rule filed Aug. 13, 1981, effective Nov. 12, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 12, 2000. Emergency amendment filed Dec. 15, 2000, effective Jan. 1, 2001, expires June 29, 2001.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 265—Division of Motor Carrier and Railroad Safety
Chapter 10—Motor Carrier Operations

EMERGENCY AMENDMENT

4 CSR 265-10.030 Insurance. The division is amending the purpose clause, inserting new sections (1) and (2), amending and renumbering current sections (1), (2), (3), (4), (6), (7) and (10), amending and renumbering current section (5) as subsection (A) of section (6), and amending section (9). Sections (8), (11), (12), and (13) are deleted entirely, but their subject matter is being revised and addressed in other sections of the rule as amended.

*PURPOSE: The division finds that this amendment is necessary to carry out the following purposes: (1) To implement the requirements and provisions of section 390.128 of section A of House Bill No. 1797, 90th Missouri General Assembly, 2nd Regular Session (effective August 28, 2000), by providing for the electronic filing of proof of insurance for motor carriers operating under the division's authority within the state; (2) To enable the division to continue carrying out its duties in registering interstate motor carriers under § 390.071, RSMo, by quickly adapting to imminent changes in the relevant federal regulations pursuant to the single, federal on-line registration system mandated by Congress in § 13908 of title 49, **United States Code**; (3) To enhance the ability and convenience of the motor carrier and insurance industries to comply with this rule and § 390.126, RSMo, by replacing the 15-day FAX*

binder authorization with provisions allowing the filing of FAX copies as final documents instead of originals; (4) To streamline or clarify the rule, and to increase compatibility with corresponding federal motor carrier insurance requirements, through text revisions that include: (a) adding topical subheadings for each section; (b) advancing the definitions from the end to the beginning of the rule; (c) adding pertinent definitions of terms defined in corresponding federal laws or regulations; (d) updating references to the relevant federal agency, laws, regulations, and the Single State Registration System, which are either obsolete, or subject to imminent changes already approved by act of Congress; (e) explaining certain procedures that were merely implied or unclear in the existing rule; (f) clarifying that cargo insurance requirements are applicable only to the transportation of household goods; (g) avoiding redundant use of terms or phrases; (h) replacing text in the passive voice with the active voice when appropriate; (i) removing unnecessary plurals when singular word forms are sufficient; and (j) condensing the text when more concise wording can be used instead.

PURPOSE: This rule [prescribes the amounts and filing requirements for insurance] ***defines and describes the procedures, forms and authorization for filing, canceling, replacing and reinstating proof of motor carrier insurance or surety bonds, and prescribes the minimum limits of public liability coverage for motor carriers of passengers or property, and minimum limits of cargo liability coverage for household goods carriers****.*

EMERGENCY STATEMENT: For the reasons described below, the Division finds that an immediate danger to the public welfare exists which requires emergency action by the division, and that this emergency amendment is necessary to preserve a compelling governmental interest, and thus requires an early effective date for this amendment as permitted pursuant to § 536.025, RSMo.

Three major legislative enactments have precipitated the division's conclusion that emergency action by the division is necessary to avoid substantial adverse impacts to Missouri's economy and the public welfare of Missouri's highways. First, Congress has enacted section 13908 of title 49, United States Code, which mandates certain reforms in the registration of interstate motor carriers by the several States, including the adoption of regulations to replace the current Single State Registration System under section 14504 of title 49, United States Code, with a single, on-line, federal system. This new federal system will serve as a clearinghouse and depository of information concerning motor carrier identification and compliance with required levels of financial responsibility (insurance coverage or surety bonds), and the preemptive effect of these federal laws and regulations will require the division to be extremely flexible in responding to the insurance requirements of this new system. The final regulations to implement this new registration system have not yet been adopted, but because it is an "on-line" system, it is evident that the electronic filing of proof of financial responsibility for interstate motor carriers will be an essential element of the system, and that states will have to adapt to an electronic filing system to participate in it.

Second, newly enacted section 390.128 of the ***Missouri Revised Statutes*** *(RSMo) authorizes the division "[t]o assist motor carriers in certifying their motor vehicle financial responsibility" pursuant to chapters 390 and 622, RSMo, by providing by rule for "the electronic filing by insurance companies of certificates of insurance required by section 390.126, RSMo . . . the confirmation of coverage by insurance companies authorized to do business in the state through national clearinghouses or private databases . . . [and] the acceptance of proof of insurance from insurance companies located outside of the state." This state statute has given MCRS authority to implement the changes affecting proof of liability insurance coverage anticipated from the new, federal, on-line motor carrier registration system, and corresponding changes for intrastate motor carriers. But to do so, the division must change its administrative rules to provide for electronic filing of insurance certificates, surety bonds, and related documents.*

Third, Congress has recently enacted the Electronic Signatures in Global and National Commerce Act, Public Law 106-229, 114 Stat. 464 (June 30, 2000). This act contains important provisions, effective October 1, 2000, which generally preempt any law from denying the validity of a signature, contract or other record relating to a transaction in or affecting interstate or foreign commerce, solely because it is in electronic form, or because a contract used an electronic signature or electronic record in its formation. Together with other provisions that will protect electronic records from legal objections on the ground that they are not in writing, and allow electronic storage and transmission of legal documents, this new law promotes electronic commerce by removing substantial legal barriers to online commercial transactions. Meanwhile, other states including California, Georgia, Massachusetts, Utah, Vermont and Washington have also introduced or adopted legislation aimed at spurring economic growth by validating electronic transactions. Emphasizing the need for prompt implementation of electronic signature legislation, legal scholars have observed that:

> *benign neglect may well produce stagnation or at least slow the development of business online. Retention of existing law during a period of rapid technological innovation can, paradoxically, create instability and uncertainty. Conversely, when law moves with change in business practice, law can actually have its most stabilizing effect and facilitate economic growth. . . . One thing is certain: great change predominates the e-commerce world, and unless we move with change, we will become its victims.*
>
> *T. Smedinghoff & R. H. Bro,* Moving with Change: Electronic Signature Legislation as a Vehicle for Advancing E-commerce, *XVII JOHN MARSHALL JOURNAL OF COMPUTER AND INFORMATION LAW 723,* et seq. *(Spring, 1999), excerpted and reprinted in FindLaw for Legal Professionals, at http://profs.lp.findlaw.com/signatures/index.html.*

If Missouri does not quickly adapt to the rapidly unfolding technologies of electronic commerce, the state's motor carriers and insurance providers could suffer competitive disadvantages and lose economic opportunities to their competitors in other states and rival industries. The division finds that excessive delay in implementing electronic insurance filing on behalf of motor carriers could subject Missouri motor carriers and insurance providers to economic disadvantages in comparison to other states and competing industries, which would adversely impact Missouri's economy and public welfare within the state.

These changes are also urgent because the highly competitive motor carrier and insurance industries need the benefits of improved customer service and reduced operating costs that are expected to result from these changes, to counteract the economic impacts of growing competition, negative pressure on prices and revenues, and increased fuel costs and other operating expenses. Electronic filing, filing of photocopies and by FAX, and other benefits of the emergency changes will enable auto liability insurers to significantly expedite the filing of required proof of liability coverage for their motor carrier clients, resulting in faster regulatory compliance, and enabling motor carriers to start business or change their insurance coverage more quickly. Because the division will provide electronic access for insurers to review the division's motor carrier data base system, and verify the insured motor carriers' status and detailed information before preparing and filing the required forms on their behalf, electronic insurance filing pursuant to this amendment will improve accuracy of the required documents and avoid technical mistakes, which can often delay and hinder compliance with insurance requirements by motor carriers, and should speed up any necessary corrections to the required documentation. These improvements should also enable insurers to reduce operating costs and increase profitability, which could attract additional insurers into the Missouri market and ben-

efit motor carriers by increased competition among insurers and possibly lower insurance premiums.

This emergency amendment also promotes a compelling governmental interest of MCRS in furthering the powers granted to the division under § 390.128, RSMo, by enabling MCRS to carry out a service contract recently signed with National Online Registries, Inc. (NOR), which is leading the development of a multistate insurance compliance database and clearinghouse system. The contract establishes terms of Missouri's participation in NOR's Electronic Motor Carrier Insurance Exchange Program for electronic filing and approval of proof of liability insurance coverage for motor carriers, along with about 15 other states who are already participating in NOR's program. The amendment is urgently needed to enable MCRS to carry out this contract, to implement the provisions of § 390.128, to participate in the single, federal on-line registration system for interstate motor carriers, and to extend the same benefits to intrastate motor carriers also. It also will enable MCRS timely to coordinate the changes to the rule with our anticipated implementation of a "paperless office" system for computerized processing of motor carrier registration and licensing applications in January, 2001, which will result in a smoother transition and reduced costs for the division.

MCRS worked with representatives of the motor carrier and insurance industries in supporting the enactment of § 390.128, RSMo. Through personal discussions, the public legislative process, conferring with several motor carrier industry groups at their annual meetings, and meeting with other state regulatory officials, motor carriers and insurance industry representatives at the National Conference of State Transportation Specialists, MCRS has discussed with and listened to industry and government agency representatives about the need for electronic insurance filing, how to implement the single, federal, on-line registration system for interstate motor carriers as mandated by 49 U.S.C. § 13908, and how to develop cost-effective methods for compliance with the division's insurance requirements. MCRS has also sent advance copies of the Emergency Amendment to representatives of the Missouri Motor Carriers Association, the Missouri Dump Truckers Association, and the Missouri Movers Association, to solicit their comments and give them an opportunity to respond to the amendment as soon as possible. These procedures are best calculated to assure fairness to all interested persons and parties under the circumstances, and to comply with the protections extended by the Missouri and United States Constitutions, without longer delaying the necessary benefits to the affected industries.

The Division has limited the scope of this Emergency Amendment to the circumstances creating the emergency and requiring emergency procedure. The substantive changes described above are necessary to respond quickly and effectively to the emergency conditions, and to avoid the adverse impacts on motor carriers, insurance providers and sureties that are anticipated if the division delays amendment of the rule during the prolonged procedures required by law for an ordinary proposed amendment. In addition, the text changes to streamline and clarify the rule are essential to promoting increased public understanding of the rule and of these substantive changes, by making the rule easier to read and understand. Significantly, the emergency changes only make additional methods of insurance filing available for motor carriers to satisfy the statutory requirements, without depriving anyone of the option to use any approved methods currently available under the existing rule.

This Emergency Amendment was filed December 15, 2000, shall become effective on January 2, 2001, and shall remain effective for one hundred eighty (180) days after that date, to expire on June 30, 2001.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) DEFINITIONS. As used in this rule, unless the context clearly indicates otherwise, the following words and terms mean:

(A) Bodily injury—Injury to the body, sickness, or disease, including death resulting from any of these.

(B) Cancellation—The termination of insurance coverage by either the insurer or the insured.

(C) Endorsement—A written amendment to the insurance policy.

(D) FMCSA—Federal Motor Carrier Safety Administration, including any successor agency or official that hereafter is authorized by federal law to administer the licensing of interstate motor carriers.

(E) Form—The standard form document that is currently specified for use by the division, including any electronic forms or data that may be approved by the division as acceptable equivalents pursuant to this rule or § 390.128, RSMo. Forms E, F, G, H, I, J, K and L referred to in this rule are incorporated by reference in this rule. The division may add, amend, or eliminate any standard forms, which may include joint or common forms used by the division in cooperation with other public governmental agencies or officials.

(F) Property damage—Damage to or loss of use of tangible property, except property that the carrier transports as cargo on its motor vehicle.

(G) Public liability—Liability for bodily injury or property damage; and with reference to the transportation of property in interstate commerce pursuant to authority granted by the FMCSA, or the transportation of any hazardous material, hazardous substance or hazardous waste in interstate or intrastate commerce, the term includes liability for environmental restoration.

(H) SSRS—The Single State Registration System established pursuant to section 14504 of title 49, *United States Code*, and part 365 of title 49, *Code of Federal Regulations*, including any successor motor carrier registration system that may be created pursuant to section 13908 of title 49, *United States Code*, and any federal regulations implementing that section, as those statutes and regulations have been or periodically may be amended.

(2) FILING OF DOCUMENTS. Insurance companies offering motor carrier insurance certificates, surety bonds, cancellation notices, or other documents for filing with the division pursuant to this rule, shall deliver the documents to the attention of the division's registration section, in the division's main office, by any of the following methods: personal delivery, U.S. mail, express courier delivery, and unless otherwise specifically ordered by the division, photocopies or FAX copies may be offered for filing instead of originals. Whenever the division determines that it has the capability, it may also receive and accept or reject these documents for filing through any national clearinghouse or private database, electronic mail (e-mail), or other approved electronic media, in conformity with section (10) of this rule. A person or company that offers photocopies, FAX copies, or electronic documents for filing shall be bound by them as if they were signed originals. All documents offered for filing shall comply with the applicable requirements and be properly signed or otherwise authenticated in accordance with this rule.

(A) Upon request, the division will acknowledge receipt of any document offered for filing pursuant to this rule by stamping or marking the document, or other method approved by the division, which shall specify the date when received. The division shall receive these documents between the hours of

8:00 a.m. and 5:00 p.m. daily, except on Saturdays, Sundays and state holidays. If any document is received by the division by FAX, e-mail, or any other electronic medium on a Saturday, Sunday or state holiday, or on any other day after 5:00 p.m. but before 8:00 a.m. on the next succeeding day, then the division shall deem it as received at 8:00 a.m. on the next succeeding day that is neither a Saturday, Sunday, nor state holiday.

(B) A document offered for filing pursuant to this rule is filed with the division when the designated division personnel have—

1. Received the completed document;

2. Made a preliminary review and determination that the document received is complete, properly authenticated, and satisfies all applicable legal requirements; and

3. Confirmed the filing by stamping or marking the document, or other method approved by the division, which shall record the date when filed.

(C) Except as provided in section (10) of this rule, whenever a document form is specified by this rule, the document shall be filed using that form.

(D) The division may reject any document filed or offered for filing pursuant to this rule, or declare it invalid at any time, and shall notify the motor carrier of the rejection or invalidity, if —

1. The motor carrier fails to comply, or to obtain compliance by its insurer or surety, with any applicable requirement of the division pursuant to this rule, section 390.126, or section 390.128, RSMo;

2. The person or persons purporting to have signed or authenticated the document fail to give the division adequate assurance of the authenticity of the document, including any signatures or copies, when requested by the division; or

3. The document is filed on paper that is either larger than eight and one-half inches wide by eleven inches high (8 1/2" × 11"), or smaller than eight and one-half inches wide by five and one-half inches high (8 1/2" × 5 1/2").

(E) Insurance certificates and surety bonds filed with the division shall not be removed from the division's custody, except as provided by law or by permission of the division director or personnel authorized by the director.

*[(1)]***(3) PROOF OF COVERAGE AND MINIMUM LIMITS OF PUBLIC LIABILITY FOR INTRASTATE CARRIERS GENERALLY.** Except as provided in section *[(2)]***(4)**, every motor carrier operating **any** motor vehicles in intrastate commerce by authority of *[the Division of Motor Carrier and Railroad Safety]* **this division** shall at all times have on file with and approved by the division a surety bond or a certificate of public liability *[and property damage]* insurance (on a form approved by the division) which shall show specifically that the required uniform endorsements are attached to the policy covering each motor vehicle in amounts not less than the following amounts:

(A) Passenger vehicles—twelve (12)-passenger or less capacity, $100,000 for injury or death of one (1) person; $300,000 for any one (1) accident; $50,000 property damage for any one (1) accident. More than twelve (12)-passenger capacity, $100,000 for injury or death of one (1) person; $500,000 for any one (1) accident; $50,000 property damage for any one (1) accident; and

(B) Freight vehicles—$100,000 for injury or death of one (1) person; $300,000 for any one (1) accident; $50,000 property damage for any one (1) accident.

*[(2)]***(4) PROOF OF COVERAGE AND MINIMUM LIMITS OF PUBLIC LIABILITY FOR INTERSTATE OR HAZARDOUS MATERIALS CARRIERS.** Every motor carrier operating **any** motor vehicles in interstate commerce in or through Missouri, and every motor carrier operating **any** motor vehicles in intrastate commerce transporting those types of commodities designated in the following table, at all times shall have on file with and approved by the division a surety bond or a certificate of public liability *[(bodily injury) and property damage]* insurance; except that**, before operating any motor vehicles within this state,** a motor carrier whose Missouri vehicle operations are exclusively in interstate commerce under *[Interstate Commerce Commission (ICC) or Federal Highway Administration (FHWA)]* **FMCSA** authority shall file proof of insurance with its registration state as required by the *Single State Registration System (SSRS) Procedures Manual* which is incorporated by reference in this rule*[.]***, or in accordance with any succeeding SSRS requirements. Except as otherwise required to comply with SSRS,** *[E]***very surety bond and insurance certificate filed pursuant to this section** shall show specifically that the required uniform endorsements are attached to the policy covering each motorvehicle in amounts not less than the amounts depicted on the following table:

SCHEDULE OF *MINIMUM* LIMITS *OF PUBLIC LIABILITY*
[(Public Liability and Property Damage Insurance)]

Type of Carriage	Commodity Transported	Amount
1) Motor carriers operating in interstate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Property (nonhazardous)	$ 750,000
2) Motor carriers operating in interstate commerce or intrastate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Hazardous substances, as defined in 49 CFR 171.8, transported in cargo tanks, portable tanks or hopper-type vehicles with capacities in excess of 3500 water gallons; or in bulk[1] Division 1.1, 1.2 and 1.3 materials, Division 2.3, Hazard Zone A, or Division 6.1, Packing Group I, Hazard Zone A materials; or in bulk Division 2.1 or 2.2; or highway route controlled quantities of a Class 7 material as defined in 49 CFR 173.403	$5,000,000
3) Motor carriers operating in interstate commerce or intrastate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Oil listed in 49 CFR 172.101; hazardous waste, hazardous materials and hazardous substances defined in 49 CFR 171.8 and listed in 49 CFR 172.101, but not mentioned in 2) or 4)	$1,000,000
4) Motor carriers operating in interstate commerce, with a gross vehicle weight rating of LESS THAN 10,000 pounds	Any quantity of Division 1.1, 1.2 or 1.3 material; any quantity of Division 2.3 Hazard zone A or Division 6.1, Packing Group I Hazard Zone A material; or highway route controlled quantities of a Class 7 material as defined in 49 CFR 173.403	$5,000,000
5) Motor carriers operating in interstate commerce	Passengers—Any vehicle with a seating capacity of 16 passengers or more	$5,000,000
	Passengers—Any vehicle with a seating capacity of 15 passengers or less	$1,500,000

[1] NOTE: As used in row number 2) of the above table, the following definitions apply:

"In bulk" means the transportation, as cargo, of property, except Division 1.1, 1.2 or 1.3 materials, and Division 2.3, Hazard Zone A gases, in containment systems with capacities in excess of 3,500 water gallons;

"In bulk" (Division 1.1, 1.2 and 1.3 explosives) means the transportation, as cargo, of any Division 1.1, 1.2 or 1.3 materials in any quantity; and

"In bulk" (Division 2.3, Hazard Zone A, or Division 6.1, Packing Group I, Hazard Zone A materials) means the transportation, as cargo, of any Division 2.3, Hazard Zone A or Division 6.1, Packing Group I, Hazard Zone A material in any quantity.

*[(3)]***(5) PUBLIC LIABILITY INSURANCE AND SURETY BOND FORMS.** The certificate of **public liability** insurance (form E) shall state that the insurer has issued to the motor carrier a policy of insurance which by endorsement provides automobile bodily injury and property damage liability insurance covering the obligations imposed upon the motor carrier by the provisions of the law of this state. The certificate shall be on form E—Uniform Motor Carrier Bodily Injury And Property Damage Liability Certificate of Insurance. The certificate shall be duly completed and executed by the insurer. The endorsement*[s]* shall be attached to the insurance policy and *[shall]* form a part of it*[, and true]*. **True** copies of the policy with the endorsement*[s]* attached shall be maintained at the motor carrier's principal place of business *[(if any)]*, **and upon request shall be produced for inspection by the division** within this state. The endorsement*[s]* shall be on form F—Uniform Motor Carrier Bodily Injury and Property Damage Liability Insurance Endorsement*[s]*. The endorsement*[s]* shall be duly completed and executed by the insurer. The form F endorsement amends the insurance policy to which it is attached to assure compliance with this rule by the motor carrier. The surety bond shall be in the form set forth in form G—Uniform Motor Carrier Bodily Injury And Property Damage Surety Bond. The bond shall be duly completed and executed by the surety and principal. *[The division shall accept, as a fifteen (15)-day binder pending the receipt of the original form, legible copies of forms E and G filed with the division by telephonic (fax) transmission. If the original form is not received by the division within fifteen (15) days after receipt of the fax, then the carrier is not in compliance with this section and the division will accept only the original form.]* **Except as otherwise required pursuant to SSRS, this section is applicable to interstate as well as intrastate motor carriers.**

*[(4)]***(6) INTRASTATE HOUSEHOLD GOODS CARGO LIABILITY—PROOF OF COVERAGE, MINIMUM LIMITS AND FORMS.** Except as otherwise provided in this rule or by division order, each *[freight-carrying]* vehicle while transporting household goods in intrastate commerce within this state shall be covered by a surety bond or certificate of cargo insurance filed with, and approved by, the division in amounts not less than the following: for loss or damage to *[property carried]* **household goods cargo** on any one (1) motor vehicle—$2500; for loss or damage to or aggregate of losses or damages of or to *[property]* **household goods cargo** occurring at any one (1) time and place—$5000.

[(A) Any shipper and contract carrier may agree upon different limits of cargo insurance than these set forth or the shipper may expressly waive the requirements of any cargo insurance. Any such agreement or waiver shall be evidenced in writing and filed with the division in lieu of policy of insurance.

(B) 49 U.S.C. sections 14501(c) and 41713(b) generally preempts the states from enacting or enforcing any law, regulation, or other provision having the force and effect of law relating to the prices, routes and services of motor carriers of property (except household goods). The division interprets this federal law as generally preempting Missouri's uniform cargo liability rules, because the Act imposes a condition requiring those rules to be optional at the request of the carrier, which is not allowed by Missouri law. This section has therefore been amended to require cargo insurance only with respect to household goods.]

[(5)] **(A)** The certificate of **cargo liability** insurance shall state that the insurer has issued to the motor carrier **of household goods** a policy of insurance which by endorsement provides cargo insurance covering the obligations imposed upon the motor carrier by provisions of the law of this state. The certificate shall be on form H—Uniform Motor Carrier Cargo Certificate Of Insurance. The certificate shall be duly completed and executed by the insurer. **The endorsement shall be attached to the insurance policy and form a part of it. True copies of the policy with the endorsement attached shall be maintained at the motor carrier's principal place of business, and upon request shall be produced for inspection by the division within this state. The endorsement shall be on form I—Uniform Motor Carrier Cargo Insurance Endorsement, which shall be duly completed and executed by the insurer. The form I endorsement amends the insurance policy to which it is attached to assure compliance with this rule by the motor carrier.** The surety bond shall be in the form set forth in form J—Uniform Motor Carrier Cargo Surety Bond. The bond shall be duly completed and executed by the surety and principal. *[The division shall accept, as a fifteen (15)-day binder pending the receipt of the original form, legible copies of forms H and J filed with the division by fax transmission. If the original form is not received by the division within fifteen (15) days after receipt of the fax, then the carrier is not in compliance with this section and the division will accept only the original form.]*

(B) An insurance company or surety shall file separate certificates or bonds, whenever it provides both cargo liability and public liability coverage for a motor carrier of household goods.

(C) Any shipper and contract carrier of household goods may agree upon different limits of cargo insurance than this section requires, or the shipper may expressly waive cargo insurance coverage for all household goods shipments transported by the contract carrier. The agreement or waiver shall be evidenced in writing and filed with the division. When agreements or waivers are filed and in effect regarding all contracting shippers that a contract carrier may serve, upon the carrier's request the division shall waive the filing of a cargo liability insurance certificate or surety bond for that carrier.

*[(6)]***(7) CANCELLATION AND REINSTATEMENT.** Except as provided in section *[(7)]***(8)** of this rule, an insurer under the provisions of this rule shall give the division not less than thirty (30) days' notice of the cancellation of motor carrier bodily injury and property damage liability insurance or motor carrier cargo insurance, by filing with the division the form of notice set forth in form K—Uniform Notice Of Cancellation Of Motor Carrier Insurance Policies. The notice shall be duly completed and executed by the insurer. A surety under the provisions of the rule shall give the division not less than thirty (30) days' notice of the cancellation of motor carrier bodily injury and property damage liability surety bond or motor carrier cargo surety bond, by filing with the division the form of notice set forth in form L—Uniform Notice Of Cancellation Of Motor Carrier Surety Bond. The notice shall be duly completed and executed by the surety or motor carrier. **After cancellation in accordance with this section, a new certificate of insurance or surety bond must be filed to reinstate coverage for the motor carrier. Except as otherwise required pursuant to SSRS, this section is applicable to interstate as well as intrastate motor carriers.**

[(7)] **(8) REPLACEMENT COVERAGE.** Policies of insurance and surety bonds required *[under]* **pursuant to** this rule may be replaced by other policies of insurance or surety bonds. The liability of the retiring insurer or surety shall be considered as having terminated on the effective date of the replacement policy of insurance or surety bond if accepted by the division; *[provided, however,]* **except** that if a cancellation notice under section *[(6)]***(7)** of this rule is received prior to receipt of the replacement certificate of insurance or surety bond, the liability of the retiring insurer or surety shall be considered as having terminated at the end of the thirty (30)-day cancellation period required in section *[(6)]***(7)** of this rule.

[(8) When the insurance company issuing the policy desires to write coverage on both public liability and property damage and cargo insurance, separate certificates and endorsements shall be used.]

(9) **AUTHORIZATION OF INSURER OR SURETY.** *[Before any policy of insurance shall be accepted by the division, the insurance company issuing the policy, or the carrier offering same,]* **Except as otherwise required pursuant to SSRS,** upon request of the division, **any insurance company that has filed or offers to file an insurance certificate** shall furnish evidence satisfactory to the division that the insurance company issuing the policy is duly authorized to transact business in Missouri and to issue the policy offered**,** and that it is financially able to meet its obligations.

(10) *[All insurance certificates and surety bonds filed with the division shall remain on file in the division and must not be removed from the division except with the written permission of the division.]* **ELECTRONIC FILING OF INSURANCE DOCUMENTS. Whenever the division determines that it has the capability, it may also accept insurance certificates, surety bonds, cancellations, or any other documents offered for filing pursuant to this rule, or §§ 390.126 or 390.128, RSMo, on behalf of intrastate or interstate motor carriers, or both, through any national clearinghouses or private databases, by electronic mail (e-mail), or by any other electronic media approved by the division.**

(A) Every motor carrier, insurance company, surety or other person that files a document electronically shall use the same document form as otherwise required by this rule, except that the division may accept for filing an electronic document containing only the particular information required of that motor carrier and insurance company, surety or other person, and the division shall incorporate by reference all other provisions of the required form. Whenever an electronic document is filed in this manner, all provisions of the required form shall be binding upon the motor carrier, insurance company, surety or other person identified in the document, to the same extent as if a fully executed paper document were filed.

(B) The division may require insurance or surety companies to use account numbers, passwords, and other forms of identification or authorization before filing a document electronically. Before the division accepts electronic documents for filing, each document shall be authenticated in a manner authorized by law and approved by the division. The division may require or accept electronic signatures, digital signatures, or other forms of authentication. The division will give public notice through the division's Internet website, or other conspicuous manner, of the approved methods of offering and authenticating documents for filing electronically.

[(11) For reinstatement of insurance which has been cancelled, a new certificate of insurance must be filed.]

[(12) Forms E, F, G, H, I, J, K and L referred to in this rule are the standard forms determined by the National Association of Regulatory Utility Commissioners and adopted for use by this division. All insurance forms to be filed with the division, including duplicates and copies shall be legible. All insurance forms shall be filed in duplicate, including the original, signed form, on paper not greater in size than eight and one-half inches wide by five inches high (8 1/2" × 5"), except as follows:

(A) One (1) copy of a fifteen (15)-day binder may be filed by facsimile transmission as provided under section (3) or section (5) of this rule;

(B) One (1) copy of the proof of insurance required by the SSRS Procedures Manual may be filed with this division as provided under section (2), and may be filed on paper not greater in size than eight and one-half inches wide by eleven inches high (8 1/2" × 11"); and

(C) Bond form G may be filed on paper not greater in size than eight and one-half inches wide by eleven inches high (8 1/2" × 11").]

[(13) As used in this rule, unless the context clearly indicates otherwise, the following words and terms mean:

(A) Cancellation—the termination of insurance coverage by either the insurer or the insured;

(B) Endorsement—a written amendment to the insurance policy;

(C) Property damage—damage to or loss of use of tangible property; and

(D) Public liability—liability for injuries to the body, sickness or disease, including death resulting from any of these, and for property damage.]

AUTHORITY: sections ***390.041, 390.071, 390.126, 390.128 and*** *622.027, RSMo [Supp. 1997]* ***2000****. Emergency rule filed June 14, 1985, effective July 1, 1985, expired Oct. 28, 1985. Original rule filed Aug. 1, 1985, effective Oct. 29, 1985. For the intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 15, 2000, effective Jan. 2, 2001, expires June 30, 2001. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 15—Division of Aging
Chapter 15—Residential Care Facilities I and II

EMERGENCY RULE

13 CSR 15-15.045 Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia

PURPOSE: This rule establishes the additional standards for those Residential Care Facilities II which admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia.

EMERGENCY STATEMENT: The Division of Aging finds a compelling governmental interest in establishing an early effective date for the following rule in order to implement the statutory requirements of section 198.073, RSMo (Supp. 1999) with regard to the establishment of additional standards for Residential Care Facilities II which admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia. Currently, there are 108,000 Missourians diagnosed with Alzheimer's disease or Alzheimer's related dementia. By 2040, the number of Missourians with Alzheimer's disease or Alzheimer's related dementia will increase fifty-six percent (56%) to more than 169,000 citizens. Ten percent (10%) of Missourians over the age of sixty-five (65) and forty percent (40%) of Missourians over the age of eighty-five (85) have Alzheimer's disease. Persons afflicted with Alzheimer's disease live an average of eight (8) years from the onset of the symptoms and nearly all will spend their last years residing in long-term care facilities. Furthermore, one-half (29,000 Missourians) of the population residing in long-term care facilities have dementia. This emergency rule is necessary to implement the provisions of section 198.073, RSMo (Supp. 1999) and establish the regulations and procedures under which residential care facilities II may admit or continue to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary. This rule preserves the com-

pelling governmental interests of safeguarding the health and welfare of elderly citizens suffering from Alzheimer's disease or other dementia by the expeditious implementation of procedures for those residential care facilities II covered under the provisions of section 198.073, RSMo (Supp. 1999) as mandated by the Missouri General Assembly. The scope of this rule is limited to the circumstances creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions.*** *The division believes this emergency rule is fair to all interested persons affected by the circumstances. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****. This emergency rule was filed December 14, 2000, effective January 2, 2001, and expires June 30, 2001.*

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

EDITOR'S NOTE: All rules relating to long-term care facilities licensed by the Division of Aging are followed by a Roman Numeral notation which refers to the class (either Class I, II or III) of standard as designated in section 198.085.1, RSMo.

(1) Definitions. For the purposes of this rule, the following definitions shall apply:

(A) Activities of daily living (ADLs) mean a resident's ability to eat, bathe, toilet, dress, transfer and ambulate.

(B) Chemical restraint means a psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.

(C) Convenience means any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interests.

(D) Discipline means any action taken by the facility for the purpose of punishing or penalizing residents.

(E) Individual Service Plan means the planning document which outlines and describes the services to be provided and the outcomes expected in order to meet the resident's needs.

(F) Licensed professional means any of the following:

1. Physician, as defined in and licensed under the provisions of Chapter 334, RSMo;

2. Nurse, as defined in and licensed under the provisions of Chapter 335, RSMo;

3. Psychologist, as defined in and licensed under the provisions of Chapter 337, RSMo;

4. Professional Counselor, as defined in and licensed under the provisions of Chapter 337, RSMo; and

5. Clinical Social Worker, as defined in and licensed under the provisions of Chapter 337, RSMo.

(G) Physical Restraint means any physically applied method, or mechanical device which the resident cannot easily remove, that restricts the free movement or normal functioning of any portion of the resident's body, or the resident's normal access to common areas and his or her personal spaces.

(H) Resident, only for the purpose of this rule, means an individual who is mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia, who is admitted to or continues to be cared for in the facility under the provisions of this rule.

(I) Significant Change means any change in the resident's physical, emotional or psychosocial condition or behavior that would require an adjustment or modification in the resident's treatment or services.

(2) General Requirements.

(A) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not care for such residents unless:

1. The resident has been diagnosed with Alzheimer's disease or other dementia by a physician licensed to practice medicine; and

2. The facility is able to provide appropriate services for and meet the needs of the resident. I/II

(B) A residential care facility II may admit or continue to care for residents who have been diagnosed with Alzheimer's disease or other dementia if the residents are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, providing the facility is in substantial compliance with the provisions of Chapter 198, RSMo and all regulations under which the facility is licensed by the Division of Aging. I/II

(C) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall comply with the provisions of the Alzheimer's Special Care Disclosure Act pursuant to sections 198.500 to 198.515, RSMo. The facility shall complete, and submit to the Division of Aging, an Alzheimer's Special Care Services Disclosure form (MO Form 886-3548), which is incorporated by reference in this rule. II

(D) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not admit, retain or continue to care for any resident who is mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids who:

1. Has exhibited behaviors which indicate that the resident is a danger to self or others;

2. Is at constant risk of elopement and, despite repeated interventions which have not altered the resident's behavior, continues to be a danger to self;

3. Requires physical or chemical restraint as defined in this rule;

4. Requires skilled nursing services as defined in section 198.006(17), RSMo for which the facility is not licensed or able to provide;

5. Requires more than one person to simultaneously provide physical assistance to the resident with any activity of daily living, with the exception of bathing; or

6. Is bed-bound or chair-bound and is unable to ambulate due to a debilitating or chronic condition. I/II

(3) Physical Design and Fire Safety Requirements.

(A) The facility shall be equipped with a complete sprinkler system installed and maintained in accordance with the 1996 edition of the National Fire Protection Association (NFPA) 13, *Standard for the Installation of Sprinkler Systems*, or the 1996 edition of NFPA 13R, *Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height,* which are incorporated by reference in this rule. I/II

(B) The facility shall be equipped with a complete electrically supervised fire alarm system in accordance with the provisions of the 1997 *Life Safety Code for Existing Health Care Occupancy*, incorporated by reference in this rule. The system shall include smoke detectors located no more than thirty feet (30') apart in corridors with no point in the corridor located more than fifteen feet (15') from a smoke detector. The fire alarm system shall be equipped to automatically transmit an alarm to the fire department. I/II

(C) Each floor used for resident bedrooms shall be divided into at least two (2) smoke sections by one (1)-hour rated smoke stop partitions. No smoke section shall exceed one hundred fifty feet (150') in length. If, however, neither the length nor width of a floor exceeds seventy-five feet (75'), no smoke stop partitions are required. Openings in smoke stop partitions shall be protected by one and three-fourths inches (1 3/4")-thick solid core wood doors or metal doors with an equivalent fire rating. The doors shall be equipped with closers and magnetic hold-open devices. Any duct passing through this smoke wall shall be equipped with automatic resetting smoke dampers that are activated by the fire alarm system. Smoke partitions shall extend from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. II

(D) In a multilevel facility, residents who are mentally incapable of negotiating a pathway to safety shall be housed only on a ground floor. The ground floor shall be any floor that has at least one exit at grade. All other required exits shall be at grade, or with no more than two steps to grade, or with a ramp to grade. The ramp shall have a maximum slope of one to twelve (1:12) leading to grade. II

(E) When a resident resides among the entire general population of the facility, the facility shall take necessary measures to provide such residents with the opportunity to explore the facility and, if appropriate, its grounds. When a resident resides within a designated, separated area that is secured by limited access, the facility shall take necessary measures to provide such residents with the opportunity to explore the separated area and, if appropriate, its grounds. If enclosed or fenced courtyards are provided, residents shall have reasonable access to such courtyards. Enclosed or fenced courtyards that are accessible through a required exit door shall be large enough to provide an area of refuge for fire safety at least thirty feet (30') from the building. Enclosed or fenced courtyards that are accessible through a door other than a required exit shall have no size requirements. II

(F) The facility shall provide freedom of movement for the residents to common areas and to their personal spaces. The facility shall not lock residents out of or inside their rooms. Key operated locks shall not be permitted on resident room doors. I/II

(G) Every facility shall use a personal electronic monitoring device for any resident whose physician recommends the use of such device. II

(H) The facility may provide a designated, separated area where residents, who are mentally incapable of negotiating a pathway to safety, reside and receive services and which is secured by limited access if the following conditions are met:

1. Dining rooms, living rooms, activity rooms, and other such common areas shall be provided within the designated, separated area. The total area for common areas within the designated, separated area shall be equal to at least forty (40) square feet per resident; II/III

2. Doors separating the designated, separated area from the remainder of the facility or building shall not be equipped with locks that require a key to open; I/II

3. If locking devices are used on exit doors egressing the facility or on doors accessing the designated, separated area, delayed egress magnetic locks shall be used. These delayed egress devices shall comply with the following:

A. The lock must unlock when the fire alarm is activated;

B. The lock must unlock when the power fails;

C. The lock must unlock within thirty (30) seconds after the release device has been pushed for at least three (3) seconds, and an alarm must sound adjacent to the door;

D. The lock must be manually reset and cannot automatically reset; and

E. A sign shall be posted on the door that reads: PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS. I/II

4. The delayed egress magnetic locks may also be released by a key pad located adjacent to the door for routine use by staff. I/II

(4) Staffing Requirements.

(A) The facility shall be staffed twenty-four (24) hours a day by the adequate number and type of personnel necessary for the proper care of residents and upkeep of the facility in accordance with the staffing requirements found in 13 CSR 15-15.042. In meeting such staffing requirements, every resident who is mentally incapable of negotiating a pathway to safety shall count as three (3) residents. I/II

(B) All on-duty staff of the facility shall, at all times, be awake, dressed in on-duty work attire, and prepared to assist residents in case of emergency. I/II

(5) Assessments and Individual Service Plans.

(A) Prior to admitting or continuing to care for a resident diagnosed with Alzheimer's disease or other dementia, a family member or legal representative of the resident, in consultation with the resident's primary physician, shall meet with a facility representative to determine if the facility can meet the needs of the resident. The facility shall document the decisions regarding admission or continued placement in the facility through written verification by the family member, physician and the facility representative. II

(B) After consultation, if the facility admits or continues to care for the resident, a Minimum Data Set (MDS) assessment shall be completed on an MDS form provided by the Division of Aging to assess the needs of each resident who is mentally incapable of negotiating a pathway to safety. II/III

(C) Each resident shall be assessed by a licensed professional, as defined in subsection (1)(F) of this rule, by use of the MDS:

1. Within ten (10) days of admission; and

2. Every one hundred-eighty (180) days thereafter; or

3. Whenever a significant change occurs in the resident's condition as defined in subsection (1)(I) of this rule. I/II

(D) Based on the MDS assessment, an interdisciplinary team shall develop an individual service plan for each resident who is mentally incapable of negotiating a pathway to safety. Whenever possible and appropriate, the resident, family members or other individuals instrumental in identifying the needs of, or providing treatment or services to, the resident shall be involved in the development or revision of the individual service plan. Every individual service plan shall be signed by each person participating in its development. II/III

(E) An individual service plan shall be completed and implemented within twenty (20) days after the completion of an MDS assessment of a resident. I/II

(F) An individual service plan shall describe the resident's needs and preferences, the specific methods and services to meet those needs, desired outcomes or interventions, and the names of the staff, service provider, and if applicable, family members who are primarily responsible for implementing the individual service plan. At a minimum, the individual service plan for each resident shall identify:

1. The resident's capabilities, strengths, potential, preferences and customary behaviors;

2. The resident's behavioral, medical and social needs based on the assessment;

3. The services provided to meet the needs of the resident;

4. The expected outcomes of the services provided; and

5. Staff or other persons responsible for providing the services to meet the needs of the resident. II/III

(G) The facility shall make each resident's individual service plan available for use to all persons providing services to that resident. II/III

(6) Staff Training and Orientation.

(A) All facility personnel who provide direct care to residents who are mentally incapable of negotiating a pathway to safety shall receive at least twenty-four (24) hours of training within the first thirty (30) days of employment.

1. At least twelve (12) hours of the twenty-four (24) hours of training shall be classroom instructions; and

2. Six (6) classroom instruction hours and two (2) on-the-job training hours shall be related to the special needs, care and safety of residents with dementia. II

(B) If residents who are mentally incapable of negotiating a pathway to safety reside among the entire general population of the facility, all facility personnel, regardless of whether such personnel provide direct care to residents who cannot negotiate a pathway to safety, shall receive on a quarterly basis at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. If residents who are mentally incapable of negotiating a pathway to safety reside within a designated, separated area that is secured by limited access, all personnel who have or could have contact with residents residing in the designated, separated area which is secured by limited access, shall receive on a quarterly basis at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. II

(C) Any training related to the special needs, treatment and safety of residents with dementia shall include, but not be limited to, the following:

1. An overview of Alzheimer's disease and other dementia;

2. Communication techniques which are effective in enhancing and maintaining communication skills for residents with dementia;

3. Components of or techniques for creating a safe, secure and socially oriented environment for residents with dementia;

4. Provision of structure, stability and a sense of routine for residents based on their needs;

5. Effective management of different or difficult behaviors; and

6. Issues involving families and care givers. II/III

(D) The initial twenty-four (24) hours of training required within the first thirty (30) days of employment shall include, at a minimum, all of the components in subsection (6)(C) of this rule. II

(E) The in-service training to be provided on a quarterly basis shall include at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. Each component listed in subsection (6)(C) of this rule must be included over the course of each twelve (12)-month period. II

(F) All in-service or orientation training relating to the special needs, care and safety of residents who are mentally incapable of negotiating a pathway to safety shall be conducted, presented or provided by a training instructor who is qualified by education, experience or knowledge in the care of individuals with Alzheimer's disease or other dementia. II/III

(7) Programs and Services for Residents Who are Mentally Incapable of Negotiating a Pathway to Safety.

(A) Each facility shall make available and implement self-care, productive and leisure activity programs for persons with dementia which maximize and encourage the resident's optimal functional ability. The facility shall provide activities that are appropriate to the resident's individual needs, preferences, background and culture. Individual or group activity programs may consist of the following:

1. Gross motor activities, such as exercise, dancing, gardening, cooking and chores;

2. Self-care activities, such as dressing, grooming and personal hygiene;

3. Social and leisure activities, such as games, music and reminiscing;

4. Sensory enhancement activities, such as auditory, olfactory, visual and tactile stimulation;

5. Outdoor activities, such as walking and field trips;

6. Creative arts; or

7. Other social, leisure or therapeutic activities that encourage mental and physical stimulation or enhance the resident's well-being. II/III

(B) The facility shall develop and implement written policies and procedures which address, at a minimum:

1. The facility's admission, transfer and discharge criteria taking into account the individual's needs and the facility's ability to meet those needs;

2. The basic services provided or offered to residents with Alzheimer's disease or other dementia;

3. The procedures and actions to be taken in the event of resident elopement;

4. The development and implementation of individual service plans;

5. The assignment of staff to residents based on the resident's needs which minimize resident confusion and maintain familiarity with environment;

6. Staff orientation and in-service training relating to the special needs, care and safety of residents with dementia;

7. Fire drill and emergency evacuation procedures for residents who are mentally incapable of negotiating a pathway to safety; and

8. The protection of the rights, privacy and safety of residents and the prevention of financial exploitation of residents. II/III

AUTHORITY: section 198.073, RSMo 2000. Emergency rule filed Dec. 14, 2000, effective Jan. 2, 2001, expires June 30, 2001. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Missouri Department of Social Services/Division of Aging
Missouri Department of Health/Division of Health Standards and Licensure
Alzheimer's Special Care Services Disclosure

PURPOSE

Long-term care facilities which provide or offer to provide care for persons with Alzheimer's disease by means of a special care unit or program are mandated by section 198.510, RSMo, to disclose information to the Division of Aging about those elements of their program which distinguishes the unit or program as being especially suitable for persons with Alzheimer's or other dementias. This disclosure form, along with a document or brochure containing information on selecting an Alzheimer's special care program, must be submitted to the Division of Aging as part of the licensure application. Facilities are also required to disclose the same information to residents, their next of kin, designee or guardian at the time of admission.

IDENTIFYING INFORMATION (PLEASE TYPE OR PRINT)

Facility Name

Address

Phone Type of License Unit Capacity

Person in Charge of Program Oversight

PROGRAM PHILOSOPHY

Briefly describe the philosophy of the Special Care Program.

ADMISSION & DISCHARGE INFORMATION

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

A. - Check the following admissions criteria and procedures that apply to the Special Care Program:

- ◯ Medical Confirmation of Alzheimer's or Related Dementia
- ◯ Pre-admission Family Interview
- ◯ Pre-admission Observation
- ◯ Tour of the Special Care Program, Explanation of Unique Features
- ◯ Additional Admission Criteria (include any other diagnostic or functional capacity requirements; ability to ambulate, etc.):

B. - Check the following discharge and/or transfer criteria and that apply to residents in the program:

- ◯ No Longer Ambulatory
- ◯ Specialized Nursing Procedures Required
- ◯ Unable to Feed Self
- ◯ Unable to Benefit from Therapuetic Programming
- ◯ Additional Criteria: _____

C. - Describe any specialized services available to assist with transfer and discharge planning for special program participants:

ASSESSMENT

A. - Describe how the process for evaluating Special Care Program participants and developing a plan of care may differ from procedures followed elsewhere in the facility.

B. - Explain how the facility ensures that staff carry out the plan of care for Special Care Program participants and how the plan of care changes in response to the participant's condition.

STAFF TRAINING

A. - Do staff who work with the Special Care Program receive specialized training not provided to staff in the rest of the facility? ◯YES ◯NO

B. - If so, indicate how many hours annually of specialized training by type of staff:

RNs & L.P.Ns: ____ Hours Per Year C.N.As: ____ Hours Per Year Support: ____ Hours Per Year Volunteers: ____ Hours Per Year

C. -List the topics of this specialized training provided to staff in the Special Care Unit:

PHYSICAL ENVIRONMENT & RESIDENT SAFTEY

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

Indicate any of the program's physical design & security features designed to safeguard individuals with Alzheimer's and dementia and enhance their lives:

◯ Door Alarms ◯ Wander Guard ◯ Enclosed Courtyard

◯ Door Locks ◯ Lockout Elevators

Other Features:

RESIDENT ACTIVITIES

List the types and frequency of activities offered by the Special Care Program which are different than those offered in the rest of the facility:

FAMILY INVOLVEMENT

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

Indicate those features available to family members of residents in the program:

- ◯ Alzheimer's Family Support Group
- ◯ Respite Care
- ◯ Support Staff Assigned to Work with Family Members
- ◯ Educational Materials on Alzheimer's & Other Dementia's

Other Features:

_____

_____

_____

_____

PROGRAM COSTS

A. - How does the cost for participants in the Special Care Program differ from the cost for other residents in the facility?

_____

_____

_____

_____

_____

B. - If there is an additional cost for participants in the Special Care Program, what additional services are provided?

_____

_____

_____

_____

_____

C. - Please indicate any other optional services available only to Special Care Program participants at an additional cost:

_____

_____

_____

_____

D. - Does the facility have designated Medicaid beds available in the Special Care Program? ◯ YES ◯ NO

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 31—Child Abuse

EMERGENCY RESCISSION

13 CSR 40-31.050 Child Fatality Review Process. This rule applied to the State Technical Assistance Team and the Child Fatality Review Panels fulfilling their responsibility in identifying and preventing child fatalities in this state.

PURPOSE: This rule is proposed for rescission because the division of family services is no longer responsible for overseeing the State Technical Assistance Team and the Child Fatality Review Process. The Director of the Department of Social Services has transferred the State Technical Assistance Team to the Division of Legal Services along with responsibility for the child fatality review process. An emergency rule and accompanying proposed rule containing the revised procedures relating to this area appear in this edition of the ***Missouri Register*** *as 13 CSR 45-2.010.*

EMERGENCY STATEMENT: The Division of Family Services (DFS) finds a compelling governmental interest in rescinding this rule with an early effective date in order to ensure the proper implementation of the provisions of Senate Bills 757 and 602 enacted by the 90th General Assembly in 2000. It is important to note that the Director of the Department of Social Services has transferred the State Technical Assistance Team (STAT) from DFS to the Division of Legal Services (DLS) along with responsibility for the child fatality review process. DLS is promulgating an emergency rule and a proposed rule, as contained in 13 CSR 45-2.010, to reflect this transfer of STAT and establish comprehensive child protective services procedures which are designed to update and supersede those contained in 13 CSR 40-31.050. If this rule is not rescinded, confusion will be created by having these two rules in existence at the same time thus adversely affecting and hampering the child protective services mission of ensuring that cases of child abuse, child neglect, child sexual abuse, child exploitation and child fatality are expeditiously reported, investigated and, in appropriate cases, prosecuted. This emergency rescission will ensure that any such confusion is avoided and that any potential danger to the health, safety and welfare of Missouri's children is eliminated. This emergency rescission will help to ensure that the expressed desires of the General Assembly of enhancing the child protective services process in this state are fully implemented through the new rulemaking promulgated by DLS. The scope of this emergency rescission is limited to the circumstances creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions.*** *DFS has followed procedures best calculated to assure fairness to interested persons and parties under the circumstances. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****. Emergency rescission filed December 19, 2000, effective January 1, 2001, expires June 29, 2001.*

AUTHORITY: section 207.020, RSMo 1986. Original rule filed June 15, 1989, effective Jan. 1, 1990. Emergency rescission and emergency rule filed Dec. 20, 1991, effective Jan. 1, 1992, expired April 29, 1992. Emergency rescission and emergency rule filed April 16, 1992, effective April 26, 1992, expired Aug. 23, 1992. Rescinded and readopted: Filed Jan. 3, 1992, effective Aug. 6, 1992. Emergency rescission filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 32—Child Care

EMERGENCY RULE

13 CSR 40-32.020 Processing of Applications for State and Federal Funds for Providing Child Care Services

PURPOSE: This emergency rule implements the provisions of section 210.025, RSMo 2000 relating to conducting background checks of persons applying for state or federal funds for providing child-care services in the home.

EMERGENCY STATEMENT: The Division of Family Services, Department of Social Services finds that this emergency rule is necessary in order to implement the provisions of section 210.025, RSMo 2000 which mandates that background checks be conducted of any person applying for state and federal funds for providing child care services in the home and of any person over the age of eighteen (18) who is living in such applicant's home. The Division finds that there exists an immediate danger to the public safety and welfare which requires emergency action inasmuch as the promulgation of this emergency rule will ensure that there are procedures in place for conducting the mandated background checks and disqualifying persons from receiving state and federal funds for providing child care services in the home when a background check has revealed that such persons are ineligible. This procedure will, therefore, provide a form of protection to children who may otherwise be placed in the care of a disqualified individual. The Division also finds that this rule is necessary to preserve a compelling governmental interest requiring an earlier effective date inasmuch as the emergency rule informs the public and all potential applicants regarding the background check requirement and disqualification procedure. This will, in turn, serve as a deterrent to those individuals who may be considering making application for federal and state funding for providing child care services in the home but who, upon learning of the stringent eligibility requirements, would not attempt to obtain eligibility because of disqualifying information that would surface during a background check. Without this emergency rule in place there could be cases where an applicant and certain household members are not given proper and thorough background screenings and, therefore, could be found eligible for receiving funds for providing child care services in the home. Such a situation would be detrimental to the safety, welfare and best interest of children cared for by such persons. This rule helps to ensure that disqualified persons are ferreted out from receiving state and federal funds for providing in-home child care services under this rule.

This emergency rule follows those procedures best calculated to ensure fairness to all interested persons and parties under the circumstances, complies with the protections extended by the ***Missouri*** *and* ***United States Constitution*** *and limits the scope of the emergency rule to the circumstances creating the emergency. Therefore, the Division believes the emergency rule to be fair to all interested persons and parties under the circumstances. Emergency rule filed December 19, 2000, effective January 1, 2001, expires June 29, 2001.*

(1) General. To qualify for receipt of state or federal funds for providing child-care services in the home either by direct payment or through reimbursement to a child-care beneficiary, an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, and any person over the age of eighteen (18) who is living in the applicant's home shall be required to submit to background checks as prescribed below. A person over the age of eighteen (18) is a person who has attained his or her eighteenth

(18th) birthday. These required background checks include the following:

(A) A criminal background check pursuant to section 43.540, RSMo;

(B) A check of the child abuse central registry established pursuant to section 210.145, RSMo; and

(C) A check of licensure suspensions and revocations pursuant to section 210.221 or 210.496, RSMo.

(2) Processing of Applications.

(A) Upon receipt of an application for state or federal funds for providing child-care services in the home, pursuant to section 210.025, RSMo, or upon review of a recipient, pursuant to 210.027, RSMo, which review shall occur at least annually, the Division of Family Services shall:

1. Determine if a probable cause (or reason to suspect) finding of child abuse or neglect involving the applicant, pursuant to section 210.025, RSMo, or the recipient, pursuant to section 210.027, or any person over the age of eighteen (18) who is living in the applicant's home has been recorded pursuant to section 210.221 or 210.145, RSMo;

2. Determine if the applicant, pursuant to section 210.025, RSMo, or the recipient, pursuant to section 210.027, or any person over the age of eighteen (18) who is living in the applicant's home has been refused licensure or has experienced licensure suspension or revocation pursuant to section 210.221 or 210.496, RSMo; and

3. Request a criminal background check pursuant to section 43.540, RSMo of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, and any person over the age of eighteen (18) who is living in the applicant's home.

(B) Except as otherwise provided in section (3) below, upon completion of the background checks required in subsection (2)(A) above, an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, shall be denied state or federal funds for providing child care if such applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, or any person over the age of eighteen (18) who is living in the applicant's home:

1. Has had a probable cause (or reason to suspect) finding of child abuse or neglect pursuant to section 210.145, RSMo;

2. Has been refused licensure or has experienced licensure suspension or revocation pursuant to section 210.496, RSMo; or

3. Has plead guilty or *nolo contendere* to or been found guilty of:

A. Any felony for an offense against the person as defined in Chapter 565, RSMo, or any other offense (misdemeanor or felony) against the person involving the endangerment of a child as prescribed by law;

B. Any misdemeanor or felony for a sexual offense as defined by Chapter 566, RSMo;

C. Any misdemeanor or felony for an offense against the family as defined in Chapter 568, RSMo, with the exception of the sale of fireworks to a child under the age of eighteen (18);

D. Any misdemeanor or felony for pornography or related offense as defined by Chapter 573, RSMo; or

E. Any similar crime in any federal, state, municipal or other court of similar jurisdiction of which the director has knowledge or any offenses or reports which will disqualify an applicant from receiving state or federal funds, including the following:

(I) murder, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(II) manslaughter, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(III) assault, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(IV) assault, in any degree, involving a child victim which is considered a misdemeanor or a felony in the jurisdiction in which it is filed; or

(V) kidnapping, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VI) felonious restraint or false imprisonment, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VII) interference with child custodial rights, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VIII) elder abuse, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(IX) adult abuse or stalking, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(X) any form of rape, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XI) any form of sodomy, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XII) any form of prostitution, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIII) any form of child molestation, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIV) any form of bigamy, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XV) any form of child abandonment, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVI) any form of criminal nonsupport of a child, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVII) any form of child endangerment, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVIII) any form of child abuse, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIX) any form of robbery, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XX) any form of arson, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXI) any form of armed criminal action, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXII) any form of unlawful possession, unlawful use, or unlawful transfer of a firearm, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXIII) any form of unlawful promotion, unlawful possession, or unlawful furnishing of obscene or pornographic materials, including, but not limited to, child pornography, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXIV) any form of unlawful possession, sale, transfer or trafficking (or any similar term in the jurisdiction in which the offense occurred) of a controlled substance, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXV) any adjudication of guilt, any plea of guilty, or any plea of *nolo contendere* in a municipal court for conduct which if prosecuted in a court of general jurisdiction would be an offense described in subdivisions (I) through (XXIV) above.

(C) Any costs associated with such checks shall be paid by the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027.

(D) Identity of the name of the applicant, pursuant to section 210.025, RSMo; or a recipient, pursuant to section 210.027, RSMo; or any person over the age of eighteen (18) who is living in the home of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, and either such person's social security number or date of birth to the name and either the social security number or date of birth of the perpetrator of an incident of child abuse or neglect, or person who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or defendant in a criminal offense shall be sufficient to find that the applicant, pursuant to section 210.025, RSMo; or a recipient, pursuant to section 210.027, RSMo; or person over the age of eighteen (18) who is living in the home of the applicant is the same person who was found to have perpetrated the child abuse or neglect, or who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or who committed the criminal offense. The applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, may present evidence to rebut this presumption. However, the presumption survives the presentation of such evidence and may be sufficient to find that the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, or person over the age of eighteen (18) who is living in the home of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, is the same person who was found to have perpetrated the child abuse or neglect, or who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or who committed the criminal offense despite the presentation of contrary evidence.

(3) Extenuating or Mitigating Circumstances. Upon completion of background checks required by this rule, the Division shall give an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, an opportunity to offer any extenuating or mitigating circumstances concerning adverse information found relating to findings of child abuse or neglect, licensure refusal or suspension, or criminal background checks against the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, or any person over the age of eighteen (18) who is living in the applicant's home. Such extenuation or mitigation may include, but is not limited to, the extent of the individual's participation in the abuse, neglect or offense; the length of time since the last incident of abuse, neglect or offense; the age of the person at the time of the abuse, neglect or offense; and remedial measures taken by the individual such as counseling, training, or therapy. In addition, the division may consider all information relating to any allegations of abuse or neglect including reports of investigation, if available. However, the fact that the report of investigation of an incident of abuse or neglect is no longer available, will not prevent the division from considering such a finding of abuse or neglect. Such a finding shall be considered along with any information the applicant wishes to present regarding the incident and any extenuating or mitigating information. Such extenuating or mitigating circumstances may be considered by the division in its determination whether to permit such applicant to receive state or federal funds for providing child care in the home.

(4) Family Care Safety Registry.

(A) The Family Care Safety Registry will contain criminal background information on only felony criminal offenses pursuant to chapters 198, 334, 560, 565, 568, 569, 573, 575, and 578, RSMo. (Section 210.909.1(4), RSMo). Providers of in-home child care services are not eligible to receive state or federal funds if they or members of their household over the age of eighteen have criminal records involving chapters 565 (felonies or any offense involving the endangerment of a child), 566 (misdemeanors or felonies), 568 (misdemeanors or felonies), 573 (misdemeanors or felonies), any offense which would disqualify the applicant or recipient from receiving state or federal funds, or of any similar crimes in any federal, state or municipal court.

(B) Because in-home child care providers are ineligible to receive state or federal funds for a different range of criminal offenses (for example, certain misdemeanors and similar crimes in any federal, state or municipal court) than would be included in the Family Care Safety Registry, applicants for direct payment or reimbursement of in-home child care services and members of their household over the age of eighteen (18) will be required to sign a request for criminal background check by the Missouri State Highway Patrol. The costs associated with this check shall be paid by the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027.

(5) Evidence. In determining whether there has been a finding of probable cause to suspect (or reason to suspect) that child abuse or neglect has been committed by an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, or a person over the age of eighteen (18) living in the applicant's home, the following shall be considered in evidence in making such determination:

(A) The letter, or a copy of the letter, from the Division of Family Services to the subject stating that there was probable cause to suspect (or reason to suspect) that the subject had committed child abuse or neglect;

(B) The letter, or a copy of the letter, from the Child Abuse and Neglect Review Board to the subject affirming the decision of the Division of Family Services which found that there was probable cause to suspect (or reason to suspect) that the subject had committed child abuse or neglect;

(C) A computer printout documenting either that the Division of Family Services made a probable cause (or reason to suspect) finding that child abuse or neglect occurred or that the Child Abuse and Neglect Review Board affirmed such finding which is otherwise authenticated pursuant to Chapter 490, RSMo, or with regard to which authentication is waived; or

(D) Any order, judgment or decree of a court of competent jurisdiction which found that the subject committed child abuse or neglect.

(E) The fact that any documentation regarding a finding of abuse or neglect, including but not limited to the report of investigation, cannot be found or has been destroyed shall not prevent that finding of abuse (otherwise documented in written or electronic form) from being considered by the division.

(6) Child Abuse or Neglect Findings: For purposes of disqualification, probable cause findings to suspect that child abuse or neglect occurred and reason to suspect findings that child abuse or neglect occurred shall be considered synonymous.

(7) All providers of child-care services in the home pursuant to this rule shall be at least eighteen (18) years old, i.e., such providers must have attained their eighteenth (18th) birthday.

(8) If there are no local ordinances or regulations regarding smoke detectors which apply to the location where the provider will be providing child-care services in the home, providers must install and maintain smoke detectors as follows:

(A) Structures Included. Smoke detectors shall be provided in all structures occupied by children in connection with child-care services in the home.

(B) Location.

1. A detector shall be mounted on the ceiling or wall at a point centrally located in a corridor or other area giving access to rooms used for providing child-care services in the home unless the manufacturer's instructions provide otherwise, then in accordance with those instructions.

2. All detectors shall be located in accordance with approved manufacturer's instructions. When actuated, the detectors shall provide an alarm in the structure or room.

(C) Duties.

1. It shall be the duty of the provider of child-care services in the home regulated by this section to provide an operable smoke alarm system.

2. It shall be the duty of the provider of child-care services in the home regulated by this section to maintain the smoke alarm system.

(9) All providers of child-care services in the home regulated by this section shall be tested at least annually for tuberculosis. Initially providers of child-care services in the home shall have a screening test (e.g., skin test). Any provider testing positive in the screening test shall submit, within one week of notice of the positive screening test, to additional, specific medical tests to verify the positive screening test and to determine if the provider is medically diagnosed with an active case of tuberculosis. If the provider is medically diagnosed with an active case of tuberculosis, the provider shall be ineligible to receive state or federal funds for the provision of child-care services in the home while the medical diagnosis of an active case of tuberculosis remains.

(10) All providers, of child-care services in the home, regulated by this section who do not have immediate access to a telephone shall notify the parents of the child(ren) of the lack of immediate access to a telephone and shall notify the parents of the child(ren) how the parents may contact the provider.

(11) Appeal. Any applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, who has been denied state or federal funds for providing child-care services in the home may appeal such denial decisions in accordance with the provisions of section 208.080, RSMo.

AUTHORITY: section 210.025, RSMo 2000. Emergency rule filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 45—Division of Legal Services
Chapter 2—State Technical Assistance Team

EMERGENCY RULE

13 CSR 45-2.010 Organization and Operation

PURPOSE: This rule describes the general organization and function of the State Technical Assistance Team including its responsibilities in providing technical assistance to Child Fatality Review Program (CFRP) panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality review. This rule also establishes and describes the functions of local (county) CFRP panels, as well as the state CFRP panel in this child protective services process.

EMERGENCY STATEMENT: This Emergency Rule is necessary to implement the provisions of Senate Bills Nos. 757 and 602 enacted by the 90th General Assembly in 2000, pertinent provisions of which are codified in sections 210.192, 210.195 and 660.520, RSMo. The Division finds that there exists an immediate danger to the health, safety and welfare of the citizens of Missouri which requires an early effective date. If this Emergency Rule is not promulgated, procedures will not be in place to ensure that cases of child abuse, child neglect, child sexual abuse, child exploitation or child fatality review are expeditiously and thoroughly reported, investigated and prosecuted in appropriate cases. The Division also finds that this Emergency Rule is necessary to preserve a compelling governmental interest of ensuring that procedures are in place to guide the State Technical Assistance Team (STAT) in fulfilling its responsibilities to provide technical assistance to the Child Fatality Review Program (CFRP) panels in fulfilling their responsibilities including submitting a final report consisting of a summary of prevention conclusions and recommendations in order that appropriate prevention responses can be made which will help to reduce the number child fatalities in this state.

This Emergency Rule will ensure that the expressed desires of the General Assembly of enhancing the child protective services process in this state are fully implemented. The scope of this Emergency Rule is limited to the circumstances creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions****. The Division has followed procedures best calculated to assure fairness to interested persons and parties under the circumstances. A proposed rule covering the same material is published in this issue of the* ***Missouri Register****. Emergency Rule filed December 19, 2000, effective January 1, 2001, expires June 29, 2001.*

(1) General Provisions and Authority. This rule is promulgated under the rulemaking authority granted to the Department of Social Services (DSS) pursuant to section 660.017, RSMo. Pursuant to Article IV, Section 37 of the *Missouri Constitution*, the Director of the Department of Social Services is charged with promoting improved health and other social services to the citizens of the State as provided by law. Section 660.010.2, RSMo authorizes the DSS Director to coordinate the state's programs devoted to those who are unable to provide for themselves and for victims of social disadvantage. Section 660.012.2, RSMo also entrusts the DSS Director with the duty to use the resources allocated to the department to provide comprehensive programs and leadership in order to improve services and economical operations. To that end, the DSS Director has determined that the transfer of the State Technical Assistance Team (STAT) from the Division of Family Services (DFS) to the Division of Legal Services (DLS) improves the efficiency and economical operations of resources and maximizes services to the citizens of this state. This rule recognizes that the transfer of STAT from DFS to DLS has been accomplished and such rule also provides a mechanism for the promulgation of procedures setting forth the function, general organization and operation of the State Technical Assistance Team. As a unit of the Division of Legal Services, STAT is responsible for performing its duties related to child fatality review pursuant to sections 210.192 to 210.196, RSMo and its duties related to providing assistance to multidisciplinary teams and law enforcement agencies in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality as prescribed in sections 660.520 to 660.527, RSMo. In performing its CFRP mission, STAT is responsible for providing training, expertise and assistance to county CFRP panels for the review of child fatalities including establishing procedures for the preparation and submission of a Final Report by CFRP panels as reflected in subsection (4)(K) of this rule.

(2) Definitions.

(A) Child abuse means any physical injury or emotional abuse inflicted on a child other than by accidental means by another person, except that discipline, including spanking, administered in a reasonable manner, shall not be construed to be abuse.

(B) Child exploitation means allowing, permitting or encouraging a child, under the age of eighteen years, to engage in prostitution or sexual conduct, as defined by state law, by a person responsible for the child's welfare or any other person involved in the act, and allowing, permitting, encouraging or engaging in the obscene or pornographic photographing, filming or depicting of a child, under the age of eighteen years, or the possession of such items, as those acts are defined by state law, by a person responsible for the child's welfare or any other person involved in the act.

(C) Child fatality means the death of a child under the age of 18 years as a result of any natural, intentional or unintentional act.

(D) Child neglect means the failure to provide, by those responsible for the care, custody and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical or any other care necessary for the child's well-being.

(E) Child sexual abuse means to engage in sexual intercourse or deviate sexual intercourse with a child or any touching of a child with the genitals, or any touching of the genitals, or anus of the child by another person, when the child is a person under the age of seventeen years.

(3) State Technical Assistance Team.

(A) The State Technical Assistance Team shall assist in the investigation of child abuse, child neglect, child sexual abuse, child exploitation or child fatality cases upon the request of:

1. A local law enforcement agency;
2. Prosecuting Attorney;
3. Division of Family Services staff;
4. A representative of the family courts;
5. Medical examiner;
6. Coroner; or
7. Juvenile officer.

(B) Upon being requested to assist in an investigation, the State Technical Assistance Team shall notify all parties specified in this subdivision of STAT's involvement in the investigation via U.S. Postal Service.

(C) Where STAT's assistance has been requested by a local law enforcement agency, STAT Investigators, certified as peace officers by the Director of the Department of Public Safety pursuant to chapter 590, RSMo shall be deemed to be peace officers within the jurisdiction of the requesting law enforcement agency, while acting at the request of the law enforcement agency. The power of arrest of a STAT Investigator, acting as a peace officer, shall be limited to offenses involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality.

(D) STAT shall assist county multi-disciplinary teams in the development and implementation of protocols for the investigation and prosecution of child abuse, child neglect, child sexual abuse, child exploitation or child fatality cases.

(E) All reports and records made and maintained by the STAT or local law enforcement relating to criminal investigations conducted pursuant to this section, including arrests, shall be available in the same manner as law enforcement records, as set forth in sections 610.100 to 610.200, RSMo, and to the individuals identified in subdivision (13) of subsection 2 of section 210.150, RSMo.

(F) An individual identified in subdivision (13) of subsection 2 of section 210.150, RSMo, is a person who is a tenure-track or full-time research faculty member at an accredited institution of higher education engaged in scholarly research and who has the permission of the Director of the Department of Social Services. Prior to the release of any identifying information the Director of the DSS shall require the researcher to present a plan for maintaining the confidentiality of the identifying information. The researcher shall be prohibited from releasing the identifying information of individual cases.

(G) All other records shall be available in the same manner as provided in section 210.150, RSMo. Nothing in this section shall preclude the release of findings or information about cases which resulted in a child fatality or near fatality. Such release is at the sole discretion of the Director of the Department of Social Services, based upon the review of the potential harm to other children with the immediate family.

(4) Local (County) Child Fatality Review Program (CFRP) Panels.

(A) The prosecuting attorney or circuit attorney shall convene a local CFRP panel in each of the state's one hundred fourteen (114) counties and St. Louis City to review suspicious child deaths.

(B) The Department of Social Services (DSS) shall convene a state CFRP panel appointed by the director of DSS to identify systemic problems and submit findings and recommendations on ways to prevent further child deaths.

(C) The local CFRP panel will review all deaths of children less than eighteen (18) years of age at the time of their death where one (1) or more of the following factors are present:

1. Sudden, unexplained death of a child under age one (1) year;
2. Unexplained/undetermined manner;
3. DFS reports on decedent or others persons in the residence;
4. Decedent in DFS custody;
5. Possible inadequate supervision of the decedent;
6. Possible malnutrition or delay in seeking medical care;
7. Possible suicide;
8. Possible inflicted injury;
9. Firearm injury;
10. Injury not witnessed by person in charge of child at time of injury;
11. Confinement;
12. Suspicious/criminal activity;
13. Drowning;
14. Suffocation or strangulation;
15. Poison/chemical/drug ingestion;
16. Severe unexplained injury;
17. Pedestrian/bicycle/driveway injury;
18. Drug/alcohol-related vehicular injury;
19. Suspected sexual assault;
20. Fire injury;
21. Autopsy by certified child death pathologist;
22. Panel discretion; or
23. Other suspicious findings (injuries such as electrocution, crush or fall).

(D) The local CFRP panel at least shall review the following information on all suspicious deaths:

1. Findings from interviews, history or death-scene investigation;
2. Physical evidence at the scene of injury, death, or both;
3. Findings from physical and medical examinations;
4. Findings from autopsy, radiological examination and laboratory evaluation;
5. Reports of investigation/evaluation; and
6. Relevant past history/agency involvement.

(E) The director of DSS shall appoint regional coordinators to serve as resources to local CFRP panels. The regional coordinators will provide the following services:

1. Consultation and technical assistance;
2. Training; and
3. Reviewing forms and provide recommendations on procedures developed by local panels.

(F) Initially, all panel members will be appointed by the prosecuting attorney. Subsequent appointments will be made by the chairperson. All members who represent a governmental agency defined as mandatory in this section will serve as long as they hold the position which made them eligible for appointment to the local CFRP panel. All other members shall serve a term which is defined in the procedures developed by the local panel. The local

procedures also shall define the selection and removal processes for non-core members. The chairperson shall be elected by the review panel. The chairperson and all other members may be reappointed for consecutive terms. The local CFRP panel shall include, but not be limited to, the following core members:

1. The prosecuting or circuit attorney;
2. Medical examiner/coroner;
3. A law enforcement officer;
4. A representative of the DFS;
5. A provider of public health services;
6. A representative of the juvenile court; and
7. A representative of emergency medical services.

(G) If the county of residence, illness/injury/event or death are different, the CFRP panel in the county where the illness/injury/event occurred shall review the death.

1. The activated review panel may communicate with the chairperson of the CFRP panel in the county of residence and death, if different, to request necessary information.

2. The review panel in the county of death, residence, or both, may choose to review the death.

3. The Coroner/Medical Examiner Data Report (Data Form 1), which is hereby incorporated by reference as part of this rule, must be completed on all children ages birth through seventeen (0–17) who die in Missouri, regardless of state of residence.

4. Children injured out of state, who die in Missouri, may be reviewed at the sole discretion of the county panel, regardless of state of residence.

(H) The panel members will hold all information obtained in the course of a review in the strictest confidence and will not discuss or disclose any information regarding any case, except as permitted by applicable statutes.

(I) DLS will not reimburse or compensate a county CFRP panel for expenses associated with review panel business. Expenses may be reimbursed consistent with state travel rules and limitations for required participation of DLS panel members in training. DFS will be responsible for payment of expenses, subject to state travel rules and limitations, and compensation for its employees who are members of a review panel.

(J) The following process will be followed by the county CFRP panels:

1. Any police officer, sheriff, law enforcement officer or official, physician, coroner/medical examiner, funeral director, hospital personnel or any person having knowledge that a person less than eighteen (18) years of age has died, shall notify the coroner or medical examiner immediately in the county of injury.

A. If the coroner or medical examiner in the county of death or residence is notified of a death, s/he shall notify the coroner or medical examiner immediately in the county of illness/injury/event, if different.

B. If the coroner or medical examiner in the county of illness/injury/event determines that the death of the person under age eighteen (18) does not exhibit any suspicious circumstances as described in this section, the panel chairperson will be responsible for cosigning Data Form 1 and shall forward the form within forty-eight (48) hours to the DSS, STAT. If the chairperson disagrees with the coroner or medical examiner regarding the nature of the death and desires a review, the review panel can be activated.

C. The coroner or medical examiner in the county of illness/injury/event shall notify a certified child death pathologist to determine the need for an autopsy. If there is disagreement, the certified child death pathologist shall make the determination, unless the CFRP panel, within twelve (12) hours, decides against the certified child death pathologist;

D. If the coroner or medical examiner determines that the child died from natural causes while under medical care, such coroner or medical examiner shall notify DFS (Central Registry Unit, "Child Abuse/Neglect Hotline—800-392-3738). In all other cases, the medical examiner or coroner shall immediately notify DFS of the child's death, as required by section 58.452, RSMo.

2. The coroner or medical examiner in the county of illness/injury/event shall notify the chairperson of the CFRP panel immediately if the death is suspicious;

3. Upon notification, the chairperson will activate the review panel within twenty-four (24) hours to review the death.

A. Each member of the panel shall share information and records available to that panel member.

B. Each review panel shall operate the review based on procedures developed by the panel and based on guidelines and protocols developed by the DSS;

4. The review panel shall determine, at a minimum;

A. The place where the injury/illness causing a death occurred;

B. The manner and circumstances of the death;

C. Actions taken by the agencies/persons involved with the child and his/her family;

D. The identification of any siblings or other children in the home of the deceased child and whether they require protection; and

E. The identification of local systemic issues or policies which enhance or detract from efforts to assist in the investigation, treatment or prevention of fatalities; and

5. The chairperson of the local CFRP panel will complete a Child Fatality Review Panel Data Report (Data Form 2), which is incorporated by reference as part of this rule, and forward it through to the DSS, STAT, for linkage with death certificates. This form must be sent within sixty (60) days of the date of death.

(K) Final Report.

1. In all cases reviewed by a CFRP panel, the CFRP shall, after completing the review, prepare a final report which shall consist of a summary of prevention conclusions and recommendations. This report shall be submitted on a form referred to as the Child Fatality Review Panel Final Report (or Final Report), which is incorporated by reference as part of this rule. Pursuant to section 210.192.3, RSMo the Final Report issued by the panel is a public record and may be obtained by submitting a written request to the following address: State Technical Assistance Team, Division of Legal Services, 2724 Merchants Drive, Jefferson City, MO 65109.

2. The CFRP panel's Final Report will be forwarded directly to the State Technical Assistance Team, Prevention Coordinator, within ten (10) days of the CFRP panel review, except in cases where criminal charges are being considered or pending. In those cases, the final report of the panel will be due within ten (10) days after a criminal indictment or information is filed in the case or the local panel chair is notified of the prosecutor's decision not to file charges.

3. The Prevention Coordinator will be a direct liaison with all CFRP panels, maintaining a prevention resource repository, and providing guidance and facilitation in the implementation of appropriate prevention strategies and responses.

4. Separate from data collected, the Prevention Coordinator will track the effectiveness of various prevention responses to specific risks, and will make this information available to the State CFRP Panel and appropriate supporting agencies.

(5) State Child Fatality Review Panel.

(A) The state CFRP panel shall be composed of a minimum of seven (7) members. All members will be appointed by the director of the DSS.

1. Members mandated by this rule to be members of this panel may serve as long as they hold the position which made them eligible for appointment.

2. The DSS shall establish procedures which define the terms for all members, reasons for the removal of members from the panel and how members will be appointed in the future.

3. The chairperson and all members may be reappointed for consecutive terms.

(B) The director of DSS shall appoint the following persons to serve on the state CFRP panel:

1. A prosecuting attorney or circuit attorney;
2. A coroner or medical examiner;
3. A law enforcement officer or official;
4. A representative from DFS;
5. A provider of public health care services;
6. A representative from the Department of Health;
7. A representative of the juvenile court; and
8. A representative of emergency medical services.

(C) Other members of the state CFRP panel may include persons from the following agencies/groups:

1. Division of Youth Services;
2. Attorney General;
3. Missouri Juvenile Justice Association;
4. A physician experienced in examining and treating abused/neglected children;
5. Department of Mental Health;
6. Department of Public Safety;
7. Department of Elementary and Secondary Education;
8. Department of Corrections; and
9. Any other professionals or citizens with special interest in child abuse and neglect.

(D) The state CFRP panel will meet at least biannually. DLS may reimburse the members who are not division employees for reasonable expenses, consistent with state travel rules and limitations for expenses associated with review panel business held outside their county of residence, but will not provide for any other compensation. DFS will be responsible for the reimbursement of expenses, subject to state travel rules and limitations, and compensation for its employees on the panel.

(E) The state CFRP panel shall review and discuss all relevant materials submitted by the local panels and the state implementation team. The purpose of the review will be to:

1. Review the findings of the county CFRP panels to determine the frequency and cause of child fatalities throughout the state;
2. Identify the appropriateness and comprehensiveness of current statutes, policies and procedures relevant to the management of fatal abuse/neglect cases;
3. Review data collected by the DSS, STAT to determine the accuracy of identification of fatally abused and neglected children;
4. Review reports on the status of the operations of the county CFRP panels; and
5. Recommend prevention strategies after reviewing statewide trends and actions suggested by local panels.

(F) The panel members will hold all information obtained in the course of a review in the strictest confidence and will not discuss or disclose any information regarding any case, except as permitted by applicable statutes.

(G) DSS and the state CFRP panel annually shall evaluate the following factors related to the work of the local CFRP panels:

1. Number of reviews;
2. Geographic area of reviews;
3. Results of reviews; and
4. Necessary amendments to the rules.

(H) The state CFRP panel shall submit findings and recommendations to the director of DSS, the governor, the speaker of the house of representatives, the president pro tempore of the senate, and the children's services commission, juvenile officers and chairperson of the local CFRP panels. At a minimum, the findings shall address the following issues:

1. The number of child fatality cases reviewed by county panels;
2. Nonidentifying characteristics for perpetrators;
3. Nonidentifying characteristics for deceased children;
4. The number of fatalities by cause(s) of death and whether death was attributable to child abuse/neglect;
5. Effectiveness of local panels; and
6. Systemic issues which need to be addressed through changes in policy, procedures or statute.

AUTHORITY: sections 210.192–210.196, 660.017 and 660.520–660.526, RSMo 2000. Emergency rule filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering the same material is published in this issue of the ***Missouri Register****.*

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CORONER/MEDICAL EXAMINER DATA REPORT

TO BE COMPLETED FOR ALL CHILD DEATHS <18 YEARS OF AGE

STATE USE ONLY		DATA FORM 1
DEATH CERT. NO.	BIRTH CERT. NO.	
CFRP CASE NO.	DECEDENT DCN	
☐ MEDICAID	CA/N INCIDENT NO.	

INSTRUCTIONS

Notify Child Abuse/Neglect Hotline (800-392-3738) of all deaths of children <18 years of age.

If county of illness/injury/event is different from county of death, complete form with all known information before forwarding to coroner or medical examiner of county of illness/injury/event.

Notify the panel chairperson of the death.

Complete the form with all known information and forward to the panel chairperson for signature.

DEATH CERTIFICATE MANNER OF DEATH
a. ☐ NATURAL d. ☐ HOMICIDE
b. ☐ ACCIDENT e. ☐ UNDETERMINED
c. ☐ SUICIDE f. ☐ PENDING

A. IDENTIFICATION INFORMATION

1.
a. ☐ Illness/injury/event is in Missouri. Complete all sections of Form 1.
b. ☐ Illness/injury/event occurred out-of-state, but death occurred in Missouri. Complete Section A only.

2. COUNTY OF RESIDENCE (STATE USE ONLY)	3. COUNTY OF ILLNESS/INJURY/EVENT (STATE USE ONLY)	4. COUNTY OF DEATH (STATE USE ONLY)

5. DECEDENT'S NAME (FIRST, MI, LAST)	6. DATE OF BIRTH (MM/DD/YY)	7. DATE OF DEATH (MM/DD/YY)
/ /	__ __/__ __/__ __	__ __/__ __/__ __

8. SEX	9. RACE	10. IS DECEDENT OF HISPANIC ORIGIN?
a. ☐ MALE	a. ☐ WHITE c. ☐ ASIAN/PACIFIC ISLANDER e. ☐ UNKNOWN	a. ☐ YES b. ☐ NO
b. ☐ FEMALE	b. ☐ BLACK d. ☐ AMERICAN INDIAN/ALASKAN NATIVE	

11. MOTHER'S NAME (FIRST, MAIDEN, LAST)	12. MOTHER'S DATE OF BIRTH
/ /	__ __/__ __/__ __

B. INDICATIONS FOR REVIEW — (ALL DEATHS)

1. Mark **all** that apply to this fatality. If one or more indicators are applicable, RSMo. 210.192 requires that the case **shall be referred** to the panel.

a. ☐ Sudden, unexplained death, age <1 year
b. ☐ Unexplained/undetermined manner
c. ☐ DFS reports on decedent or other persons in the residence
d. ☐ Decedent in DFS custody
e. ☐ Possible inadequate supervision
f. ☐ Possible malnutrition or delay in seeking medical care
g. ☐ Possible suicide
h. ☐ Possible inflicted injury
i. ☐ Firearm injury
j. ☐ Injury not witnessed by person in charge at time of injury
k. ☐ Confinement
l. ☐ Suspicious/criminal activity
m. ☐ Drowning
n. ☐ Suffocation or strangulation
o. ☐ Poison/chemical/drug ingestion
p. ☐ Severe unexplained injury
q. ☐ Pedestrian/bicycle/driveway injury
r. ☐ Motor vehicle injury
s. ☐ Suspected sexual assault
t. ☐ Fire injury
u. ☐ Autopsy by certified child death pathologist
v. ☐ Panel discretion
w. ☐ Other suspicious findings (injuries such as electrocution, crush or fall)

2. Referral to Panel (Mark one)

a. ☐ One or more of the indicators marked above apply in this fatality. The case **shall be referred** to the review panel.
b. ☐ None of the indicators listed apply in this fatality. The case is not referred to the panel.

C. CHILD ABUSE/NEGLECT HOTLINE (800-392-3738)

Notify Child Abuse/Neglect Hotline of all deaths of children <18 years of age.

1. Were there prior reports to the Child Abuse/Neglect Hotline? a. ☐ Yes b. ☐ No
If yes, mark all that apply:

1. ☐ Involving child
2. ☐ Involving anyone else in family
3. ☐ Involving caretaker (other than family)
4. ☐ Total number of DFS reports _____

2. Current notification to Child Abuse/Neglect Hotline was accepted as:

a. ☐ Information only b. ☐ Report for investigation

3. Person reporting death to the hotline? _____

MO 886-3219 (10-00)

CONTINUE ON PAGE 2

D. SOCIAL INFORMATION

1. For all persons living in the residence of the decedent, indicate their relationship to the decedent, their age range, and who is head of household. (Select only one head of household)

Use corresponding letter for appropriate age range:

A = 0-5 yrs. **B** = 6-9 yrs. **C** = 10-14 yrs. **D** = 15-18 yrs. **E** = 19-40 yrs. **F** = >40 yrs.

	Age Range	Head of Household		Age Range	Head of Household
a. ☐ Natural father	____	☐	i. ☐ Other relative	____	☐
b. ☐ Natural mother	____	☐	j. ☐ Other relative	____	☐
c. ☐ Adoptive father	____	☐	k. ☐ Mother's paramour	____	☐
d. ☐ Adoptive mother	____	☐	l. ☐ Father's paramour	____	☐
e. ☐ Stepfather	____	☐	m. ☐ Other non-relative	____	☐
f. ☐ Stepmother	____	☐	n. ☐ Another child	____	☐
g. ☐ Foster father	____	☐	o. ☐ Another child	____	☐
h. ☐ Foster mother	____	☐	p. ☐ More than two children (list in narrative)		

2. Current marital status of head of household?

a. ☐ Married c. ☐ Divorced e. ☐ Unknown
b. ☐ Widowed d. ☐ Never married

E. DEATH/SCENE INFORMATION

1. Place of Injury/Event?

a. ☐ Decedent's home e. ☐ Public drive i. ☐ Other private property m. ☐ Body of water
b. ☐ Other home f. ☐ Street j. ☐ Licensed child care facility n. ☐ Work place
c. ☐ Rural road g. ☐ Private drive k. ☐ Unlicensed child care facility o. ☐ Hospital
d. ☐ Highway h. ☐ Farm l. ☐ Child care residential facility p. ☐ Other: _____

2. Date of injury/event? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY) b. ☐ Unknown

3. Time of injury/event? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

4. Time pronounced dead? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

5. Was an autopsy performed? a. ☐ Yes b. ☐ No c. ☐ Unknown

If yes:
1. ☐ By CFRP pathologist?
2. ☐ By hospital physician?

NOTE: Autopsies performed by non-certified Child Death Pathologists are limited to hospital deaths resulting from a **known** medical condition/illness. All others are to be done by a Child Death Pathologist (see listing at www.dss.state.mo.us/stat/cpn.htm). Only CFRP pathologist autopsies qualify for reimbursement.

3. Name of CFRP pathologist? (Last name only) _____

F. SUPERVISION

1. Who was in charge of watching the decedent at the time of injury/event?

a. ☐ Natural father g. ☐ Foster father m. ☐ Unlicensed babysitter/child care worker
b. ☐ Natural mother h. ☐ Foster mother n. ☐ Child, age: _____
c. ☐ Adoptive father i. ☐ Other relative o. ☐ Hospital staff
d. ☐ Adoptive mother j. ☐ Parent's male paramour p. ☐ Other non-relative
e. ☐ Stepfather k. ☐ Parent's female paramour q. ☐ No one in charge of watching
f. ☐ Stepmother l. ☐ Licensed babysitter/child care worker r. ☐ Due to age, no one in charge

2. Was the decedent adequately supervised? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

If no:

1. Did the person(s) in charge appear to be intoxicated, under influence of drugs, mentally ill or limited, or otherwise impaired at time of injury/event?
   a. ☐ Yes b. ☐ No c. ☐ Unknown

2. Was the person(s) preoccupied, distracted or asleep at the time of the injury/event?
   a. ☐ Yes b. ☐ No c. ☐ Unknown

3. Was injury/event witnessed by at least one person? a. ☐ Yes b. ☐ No c. ☐ Unknown

G. CAUSE OF DEATH
(Select most appropriate cause of death and if applicable, complete Section H)

1. ☐ INJURY (Complete questions 1 and 2 for all injuries)

1. Was the injury inflicted? a. ☐ Yes b. ☐ No c. ☐ Unknown
   (Inflicted - defined as assaultive or aggressive action)
2. Was the injury intentional? a. ☐ Yes b. ☐ No c. ☐ Unknown

If vehicle accident, non-reviewable, answer questions 3 through 9. If reviewable vehicle accident (pedestrian/bicycle/driveway injury, drug/alcohol related or other suspicious/criminal activity), skip the following questions and complete Section H.

3. Position of decedent?
   a. ☐ Operator c. ☐ Other
   b. ☐ Passenger d. ☐ Unknown
4. Vehicle in which decedent was occupant?
   a. ☐ Car c. ☐ Motorcycle/ATV e. ☐ Semi/Tractor trailer unit
   b. ☐ Truck/RV/Van d. ☐ Farm vehicle f. ☐ Other
5. Was another vehicle involved in accident? a. ☐ Yes b. ☐ No
6. Condition of road?
   a. ☐ Normal c. ☐ Wet e. ☐ Other
   b. ☐ Loose gravel d. ☐ Ice or snow f. ☐ Unknown
7. Restraint used by decedent?
   a. ☐ Present, not used c. ☐ Used correctly e. ☐ Unknown
   b. ☐ None in vehicle d. ☐ Used incorrectly f. ☐ Not applicable
8. Helmet used by decedent?
   a. ☐ Helmet worn b. ☐ Helmet not worn c. ☐ Not applicable
9. Primary cause of accident?
   a. ☐ Speeding c. ☐ Mechanical failure e. ☐ Driver error
   b. ☐ Carelessness d. ☐ Weather conditions f. ☐ Other

2. ☐ ILLNESS OR OTHER NATURAL CAUSE

1. Known condition _____
2. Was inadequate care or neglect involved in death? a. ☐ Yes b. ☐ No
   (If yes, mark Section H, Number 2)

Complete questions 3 - 8 if death in infant <1 year of age.

3. History information provided by? a. ☐ Parent b. ☐ Physician/Medical facility c. ☐ Other
4. Age at death?
   a. ☐ 0 - 24 hours after birth c. ☐ 48 hours - 6 weeks e. ☐ 6 months - 1 year
   b. ☐ 24 - 48 hours d. ☐ 6 weeks - 6 months
5. Gestational age?
   a. ☐ <25 weeks b. ☐ 25 - 30 weeks c. ☐ 30-37 weeks d. ☐ >37 weeks e. ☐ Unknown
6. Birth weight in grams (approximate lbs./oz.)?
   a. ☐ <750 (<1 lb. 10 oz.) c. ☐ 1,500 - 2,499 (3 lbs. 6 oz. to 5 lbs. 5 oz.) e. ☐ Unknown
   b. ☐ 750 - 1,499 (1 lb. 10 oz. to 3 lbs. 5 oz.) d. ☐ >2,500 (>5 lbs. 6 oz.)
7. Multiple birth? a. ☐ Yes b. ☐ No
8. Have there been other infant deaths in the immediate family? a. ☐ Yes b. ☐ No c. ☐ Unknown

3. ☐ UNKNOWN CAUSE (Describe in narrative. Death shall be reviewed.)

1. Was death sudden and unexplained in infant <1 year of age, but over 1 week old? a. ☐ Yes b. ☐ No
   (If yes, the child is required to be autopsied by child death pathologist)
   If yes, also complete Section G, Number 2, questions 3 - 8 and mark Section H, Number 1.

MO 886-3219 (10-00)

CONTINUE ON PAGE 4

H. CIRCUMSTANCES OF DEATH

If any of the circumstances are applicable, death shall be reviewed.

1. ☐ Sudden Unexplained Death of Infant <1 Year
2. ☐ Inadequate Care or Neglect
3. ☐ Vehicular
   (Includes pedestrian/bicycle/driveway injury, drug/alcohol related, or other suspicious/criminal activity)
4. ☐ Drowning
5. ☐ Firearm
6. ☐ Suffocation/Strangulation
7. ☐ Electrocution
8. ☐ Fall Injury
9. ☐ Poisoning/Overdose
10. ☐ Fire/Burn
11. ☐ Crush
12. ☐ Confinement
13. ☐ Shaken/Impact Syndrome
14. ☐ Other Inflicted Injury
    (Describe in narrative)
15. ☐ Other Circumstances
    (Describe in narrative)

I. NARRATIVE DESCRIPTION OF CIRCUMSTANCES OR OTHER COMMENTS

SEND COMPLETED DATA FORM 1 TO:

STATE TECHNICAL ASSISTANCE TEAM
2724 MERCHANTS DRIVE, JEFFERSON CITY, MO 65109
573-751-5980 OR 800-487-1626
FAX: 573-751-1479

CORONER/MEDICAL EXAMINER SIGNATURE ▶	REFER TO CFRP? a. ☐ YES b. ☐ NO	DATE (MM/DD/YY) __ __ / __ __ / __ __
CFRP CHAIR SIGNATURE ▶	REFER TO CFRP? a. ☐ YES b. ☐ NO	DATE (MM/DD/YY) __ __ / __ __ / __ __
REGIONAL COORDINATOR SIGNATURE		DATE (MM/DD/YY) __ __ / __ __ / __ __

MO 886-3215 (10-90) PAGE 4

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CHILD FATALITY REVIEW PANEL DATA REPORT

TO BE COMPLETED FOR ALL REVIEWABLE CHILD DEATHS <18 YEARS OF AGE

STATE USE ONLY		DATA FORM 2
DEATH CERT. NO	BIRTH CERT. NO.	
CFRP CASE NO.	DECEDENT DCN	
☐ MEDICAID	CA/N INCIDENT NO.	

DEATH CERTIFICATE MANNER OF DEATH
a. ☐ NATURAL d. ☐ HOMICIDE
b. ☐ ACCIDENT e. ☐ UNDETERMINED
c. ☐ SUICIDE f. ☐ PENDING

INSTRUCTIONS

Notify Child Abuse/Neglect Hotline (800-392-3738) of all deaths of children <18 years of age.

Complete the form with all known information and forward to the regional coordinator within forty-five days of the death.

A. IDENTIFICATION INFORMATION

1. COUNTY OF RESIDENCE (STATE USE ONLY)	2. COUNTY OF ILLNESS/INJURY/EVENT (STATE USE ONLY)	3. COUNTY OF DEATH (STATE USE ONLY)

4. DECEDENT'S NAME (FIRST, MI, LAST)	5. DATE OF BIRTH (MM/DD/YY)	6. DATE OF DEATH (MM/DD/YY)
/ /	__ __/__ __/__ __	__ __/__ __/__ __

7. SEX	8. RACE	9. IS DECEDENT OF HISPANIC ORIGIN?
a. ☐ MALE	a. ☐ WHITE c. ☐ ASIAN/PACIFIC ISLANDER e. ☐ UNKNOWN	a. ☐ YES b. ☐ NO
b. ☐ FEMALE	b. ☐ BLACK d. ☐ AMERICAN INDIAN/ALASKAN NATIVE	

10. MOTHER'S NAME (FIRST, MAIDEN, LAST)	11. MOTHER'S DATE OF BIRTH (MM/DD/YY)
/ /	__ __/__ __/__ __

B. CHILD ABUSE/NEGLECT HOTLINE (800-392-3738)

1. Were there prior reports to the Child Abuse/Neglect Hotline? a. ☐ Yes b. ☐ No

If yes, mark all that apply:

1. ☐ Involving child
2. ☐ Involving anyone else in family
3. ☐ Involving caretaker (other than family)
4. ☐ Total number of DFS reports _____

2. Current notification to Child Abuse/Neglect Hotline was accepted as:

a. ☐ Information/Referral only b. ☐ Report for investigation

C. SOCIAL INFORMATION

1. For all persons living in the residence of the decedent, indicate their relationship to the decedent, their age range, and who is head of household. (Select only one head of household)

Use corresponding letter for appropriate age range:

A = 0-5 yrs. **B** = 6-9 yrs. **C** = 10-14 yrs. **D** = 15-18 yrs. **E** = 19-40 yrs. **F** = >40 yrs.

	Age Range	Head of Household		Age Range	Head of Household
a. ☐ Natural father		☐	i. ☐ Other relative		☐
b. ☐ Natural mother		☐	j. ☐ Other relative		☐
c. ☐ Adoptive father		☐	k. ☐ Mother's paramour		☐
d. ☐ Adoptive mother		☐	l. ☐ Father's paramour		☐
e. ☐ Stepfather		☐	m. ☐ Other non-relative		☐
f. ☐ Stepmother		☐	n. ☐ Another child		☐
g. ☐ Foster father		☐	o. ☐ Another child		☐
h. ☐ Foster mother		☐	p. ☐ More than two children (list in narrative)		

2. Current marital status of head of household?

a. ☐ Married c. ☐ Divorced e. ☐ Unknown
b. ☐ Widowed d. ☐ Never married

D. DEATH/SCENE INFORMATION

1. Place of death?

a. ☐ Decedent's home
b. ☐ Other home
c. ☐ Rural road
d. ☐ Highway
e. ☐ Public drive
f. ☐ Street
g. ☐ Private drive
h. ☐ Farm
i. ☐ Other private property
j. ☐ Licensed child care facility
k. ☐ Unlicensed child care facility
l. ☐ Child care residential facility
m. ☐ Body of water
n. ☐ Work place
o. ☐ Hospital
p. ☐ Other: _____

2. Date of injury/event? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY) b. ☐ Unknown

3. Time of injury/event? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

4. Time pronounced dead? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

5. Autopsy performed by? a. ☐ CFRP Pathologist (Last Name Only) _____
b. ☐ Not performed

E. SUPERVISION

1. Who was in charge of watching the decedent at the time of injury/event?

a. ☐ Natural father
b. ☐ Natural mother
c. ☐ Adoptive father
d. ☐ Adoptive mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster father
h. ☐ Foster mother
i. ☐ Other relative
j. ☐ Parent's male paramour
k. ☐ Parent's female paramour
l. ☐ Licensed babysitter/child care worker
m. ☐ Unlicensed babysitter/child care worker
n. ☐ Child, age: _____
o. ☐ Hospital staff
p. ☐ Other non-relative
q. ☐ No one in charge of watching
r. ☐ Due to age, no one in charge

2. Was the decedent adequately supervised? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

If no:

1. Did the person(s) in charge appear to be intoxicated, under influence of drugs, mentally ill or limited, or otherwise impaired at time of injury/event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

2. Was the person(s) preoccupied, distracted or asleep at the time of the injury/event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

3. Was injury/event witnessed by at least one person? a. ☐ Yes b. ☐ No c. ☐ Unknown

F. PANEL FINDINGS

1. Date of first panel meeting? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY)

2. Panel members participating?

a. ☐ Coroner
b. ☐ Prosecutor
c. ☐ DFS worker
d. ☐ Public health/Physician
e. ☐ EMS
f. ☐ Medical examiner
g. ☐ Law enforcement officer
h. ☐ Juvenile officer
i. ☐ Optional member
j. ☐ Optional member

3. Total number of meetings held? a. ☐ One b. ☐ Two c. ☐ Three or more

4. Death scene investigation conducted? (Mark all that apply)

a. ☐ By law enforcement
b. ☐ By coroner
c. ☐ By medical examiner
d. ☐ By EMS
e. ☐ By fire investigator
f. ☐ By other agency
g. ☐ Not conducted

5. Investigation by law enforcement?

a. ☐ Conducted, no arrest b. ☐ Conducted, arrest for: _____ c. ☐ Pending d. ☐ Not conducted

6. Investigation/evaluation by juvenile officer?

a. ☐ Conducted, no action b. ☐ Conducted, juvenile court action c. ☐ Pending d. ☐ Not conducted

7. Review of records by Department of Health?

a. ☐ Conducted, no action b. ☐ Conducted, services provided c. ☐ Pending d. ☐ Not conducted

MO 886-3218 (4-99)

CONTINUE ON PAGE 3

PAGE 2

8. Review of history by Division of Family Services?

a. ☐ Conducted, no action c. ☐ Conducted, case investigation e. ☐ Not conducted
b. ☐ Conducted, services provided d. ☐ Pending

9. Action by prosecutor?

a. ☐ Suspected perpetrator, no charge filed c. ☐ Pending or in progress
b. ☐ Charge filed for: _____ d. ☐ No action

10. Review of medical/trip records by EMS?

a. ☐ Conducted, no action b. ☐ Conducted, services provided c. ☐ Pending d. ☐ Not conducted

11. Did the review lead to additional investigation? a. ☐ Yes b. ☐ No

12. Were additional services provided as a result of the review? a. ☐ Yes b. ☐ No

13. Were changes in agency policies or practices recommended as a result of the review? a. ☐ Yes b. ☐ No

G. PERSON(S) ARRESTED/CHARGED

If no arrest or charge, go to Section H

1. Number of person(s) arrested/charged? a. ☐ One b. ☐ Two c. ☐ Three or more

2. Number of persons arrested or charged under 18 years of age?

a. ☐ One b. ☐ Two c. ☐ Three or more d. ☐ Not applicable

3. Was one or more of the persons arrested or charged responsible for supervision of the child at time of fatal illness/injury/event?

a. ☐ Yes b. ☐ No

4. Indicate the relationship of the person(s) arrested or charged to the decedent.

a. ☐ Natural father
b. ☐ Natural mother
c. ☐ Adoptive father
d. ☐ Adoptive mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster father
h. ☐ Foster mother
i. ☐ Other relative
j. ☐ Sibling
k. ☐ Parent's male paramour
l. ☐ Parent's female paramour
m. ☐ Babysitter/child care worker
n. ☐ Friend
o. ☐ Acquaintance
p. ☐ Other non-relative
q. ☐ Other non-relative
r. ☐ Stranger

H. CAUSE OF DEATH

Complete Section appropriate to death

1. ☐ **INJURY (If marked, also complete Section I)**

1. Was the injury inflicted? a. ☐ Yes b. ☐ No c. ☐ Unknown
(Inflicted - defined as assaultive or aggressive action)

2. Was the injury intentional? a. ☐ Intentional b. ☐ Unintentional/Accidental c. ☐ Unknown

3. If intentional, was decedent? a. ☐ Intended victim b. ☐ Random victim

4. Person(s) inflicting injury? (Mark all that apply)

a. ☐ Self
b. ☐ Mother
c. ☐ Father
d. ☐ Stepmother
e. ☐ Stepfather
f. ☐ Mother's paramour
g. ☐ Father's paramour
h. ☐ Foster parent
i. ☐ Other relative
j. ☐ Acquaintance
k. ☐ Friend
l. ☐ Child care worker
m. ☐ Sibling
n. ☐ Other child
o. ☐ Stranger
p. ☐ Unknown

5. Age of primary person inflicting injury? a. ☐ _____ b. ☐ Unknown

6. Race of primary person inflicting injury?

a. ☐ White
b. ☐ Black
c. ☐ Asian/Pacific Islander
d. ☐ American Indian/Alaskan Native
e. ☐ Unable to determine
f. ☐ Unknown

7. Was the injury drug related? a. ☐ Yes b. ☐ No c. ☐ Unknown
8. Was the injury gang related? a. ☐ Yes b. ☐ No c. ☐ Unknown
9. Did the injury occur during commission of a crime? a. ☐ Yes b. ☐ No c. ☐ Unknown
10. If suicide: (Mark all that apply)
    a. ☐ Prior attempts
    b. ☐ Talked of suicide
    c. ☐ Prior mental health problems
    d. ☐ Had previously received mental health services
    e. ☐ Suicide completely unexpected

2. ☐ **ILLNESS OR OTHER NATURAL CAUSE**
(If applicable, complete Inadequate Care or Neglect in Section I)

1. ☐ Known Condition _____

Complete questions 2 - 11 if natural cause death in infant <1 year of age (INCLUDING SIDS)

2. Age at death?
    a. ☐ 0 - 24 hours after birth
    b. ☐ 24 - 48 hours
    c. ☐ 48 hours - 6 weeks
    d. ☐ 6 weeks - 6 months
    e. ☐ 6 months - 1 year
3. Gestational age at birth?
    a. ☐ <25 weeks b. ☐ 25 - 30 weeks c. ☐ 30 - 37 weeks d. ☐ >37 weeks e. ☐ Unknown
4. Birth weight in grams (approximate lbs./oz.)?
    a. ☐ < 750 (<1 lb. 10 oz.)
    b. ☐ 750 - 1,499 (1 lb. 10 oz. to 3 lbs. 5 oz.)
    c. ☐ 1,500 - 2,499 (3 lbs. 6 oz. to 5 lbs. 5 oz.)
    d. ☐ >2,500 (>5 lbs. 6 oz.)
    e. ☐ Unknown
5. Multiple birth? a. ☐ Yes b. ☐ No
6. Total number of prenatal visits?
    a. ☐ None b. ☐ 1 - 3 c. ☐ 4 - 6 d. ☐ 7 - 10 e. ☐ Unknown
7. First prenatal visit occurred during?
    a. ☐ First trimester b. ☐ Second trimester c. ☐ Third trimester d. ☐ Unknown
8. Medical complications during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown
9. Smoking during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown
10. Drug use during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown
11. Alcohol use during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown

3. ☐ **UNKNOWN CAUSE (Describe in narrative)**

I. CIRCUMSTANCES OF DEATH

1. ☐ **SUDDEN INFANT DEATH SYNDROME** (Also complete Section H-2, questions 2-11)

1. Position of decedent at discovery?
    a. ☐ On stomach, face down
    b. ☐ On stomach, face to side
    c. ☐ On stomach, face position unknown
    d. ☐ On back
    e. ☐ On side
    f. ☐ Unknown
2. Normal sleeping position?
    a. ☐ On Back b. ☐ On stomach c. ☐ On side d. ☐ Varies e. ☐ Unknown
3. Location of decedent when found?
    a. ☐ Crib b. ☐ Playpen c. ☐ Bed d. ☐ Couch e. ☐ Floor f. ☐ Other g. ☐ Unknown
4. Was decedent sleeping alone?
    a. ☐ Yes b. ☐ No c. ☐ Unknown

2. ☐ INADEQUATE CARE OR NEGLECT (Mark all that apply)

a. ☐ Apparent lack of supervision
b. ☐ Apparent lack of medical care
c. ☐ Munchausen Syndrome by Proxy
d. ☐ Failure to Thrive (non-organic)
e. ☐ Malnutrition
f. ☐ Dehydration
g. ☐ Oral water intoxication
h. ☐ Delayed medical care
i. ☐ Inadequate medical attention
j. ☐ Out-of-hospital birth
k. ☐ Other

3. ☐ VEHICLE ACCIDENT

1. Position of decedent?

a. ☐ Operator
b. ☐ Pedestrian
c. ☐ Passenger
d. ☐ Bicyclist
e. ☐ Other
f. ☐ Unknown

2. Vehicle in which decedent was occupant?

a. ☐ Car
b. ☐ Truck/RV/Van
c. ☐ Motorcycle
d. ☐ Bicycle
e. ☐ Riding mower
f. ☐ Farm tractor
g. ☐ Other farm vehicle
h. ☐ All-terrain vehicle
i. ☐ Semi/Tractor trailer unit
j. ☐ Other
k. ☐ Not applicable

3. Vehicle in which decedent was not occupant?

a. ☐ Car
b. ☐ Truck/RV/Van
c. ☐ Motorcycle
d. ☐ Bicycle
e. ☐ Riding mower
f. ☐ Farm tractor
g. ☐ Other farm vehicle
h. ☐ All-terrain vehicle
i. ☐ Semi/Tractor trailer unit
j. ☐ Other
k. ☐ Not applicable

4. Condition of road?

a. ☐ Normal b. ☐ Loose gravel c. ☐ Wet d. ☐ Ice or snow e. ☐ Other f. ☐ Unknown

5. Restraint used?

a. ☐ Present, not used
b. ☐ None in vehicle
c. ☐ Used correctly
d. ☐ Used incorrectly
e. ☐ Unknown
f. ☐ Not applicable

6. Helmet used?

a. ☐ Helmet worn
b. ☐ Helmet not worn
c. ☐ Not applicable

7. Alcohol and/or other drug use?

a. ☐ Decedent impaired
b. ☐ Driver of decedent's vehicle impaired
c. ☐ Driver of other vehicle impaired
d. ☐ Not applicable

8. Primary cause of accident?

a. ☐ Speeding
b. ☐ Carelessness
c. ☐ Mechanical failure
d. ☐ Weather conditions
e. ☐ Driver error
f. ☐ Other
g. ☐ Unknown

4. ☐ DROWNING

1. Place of drowning?

a. ☐ Lake, river, pond or creek
b. ☐ Bathtub
c. ☐ Swimming pool
d. ☐ Well/Cistern
e. ☐ Bucket
f. ☐ Wading pool
g. ☐ Other
h. ☐ Unknown

2. Activity at time of drowning?

a. ☐ Boating
b. ☐ Playing at water's edge
c. ☐ Swimming
d. ☐ Playing
e. ☐ Other
f. ☐ Unknown

3. Was decedent wearing a floatation device? a. ☐ Yes b. ☐ No

4. Did decedent enter area of water unattended? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

5. Could decedent swim? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

6. Were alcohol or drugs a factor? a. ☐ Yes b. ☐ No

5. ☐ FIREARM

1. Person handling the firearm?
   a. ☐ Decedent b. ☐ Family member c. ☐ Acquaintance d. ☐ Stranger e. ☐ Unknown
2. Type of firearm?
   a. ☐ Handgun b. ☐ Rifle c. ☐ Shotgun d. ☐ Other e. ☐ Unknown
3. Age of person handling firearm? a. ☐ _____ b. ☐ Unknown
4. Use of firearm at time of injury?
   a. ☐ Shooting at other person d. ☐ Target shooting g. ☐ Playing
   b. ☐ Shooting at self e. ☐ Loading firearm h. ☐ Other
   c. ☐ Cleaning firearm f. ☐ Hunting i. ☐ Unknown
5. Did person handling firearm attend safety classes? a. ☐ Yes b. ☐ No c. ☐ Unknown

6. ☐ SUFFOCATION/STRANGULATION

1. Cause of suffocation/strangulation?
   a. ☐ Other person overlaying or rolling over decedent
   b. ☐ Wedging
   c. ☐ Food
   d. ☐ Other person's hand(s)
   e. ☐ Object covering decedent's mouth/nose
   f. ☐ Object exerting pressure on victim's neck/chest
   g. ☐ Small object or toy in mouth
   i. ☐ Other
   j. ☐ Unknown
2. If sleeping, location of decedent at the time?
   a. ☐ In crib c. ☐ In couch/chair e. ☐ In infant car seat g. ☐ Other
   b. ☐ In bed d. ☐ Being held f. ☐ On floor h. ☐ Unknown
3. If sleeping, was decedent sleeping alone?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
4. If bedding was involved:
   1. Was the design of bed hazardous?
      a. ☐ Yes b. ☐ No c. ☐ Unknown
   2. Was decedent placed on soft bedding?
      a. ☐ Yes b. ☐ No c. ☐ Unknown
   3. Was there improper use of bedding?
      a. ☐ Yes b. ☐ No c. ☐ Unknown

7. ☐ ELECTROCUTION

1. Source of electricity?
   a. ☐ Water contact c. ☐ Electrical outlet e. ☐ Tool g. ☐ Other
   b. ☐ Electrical wire d. ☐ Appliance f. ☐ Lightening h. ☐ Unknown

8. ☐ FALL INJURY

1. Fall was from?
   a. ☐ Open window c. ☐ Natural elevation e. ☐ Man-made elevation
   b. ☐ Furniture d. ☐ Stairs or steps f. ☐ Other
2. Height of fall? a. ☐ # feet _____ b. ☐ Unknown
3. Landing surface composition/hardness? a. ☐ Carpet b. ☐ Concrete c. ☐ Ground d. ☐ Other
4. Was decedent in a baby walker? a. ☐ Yes b. ☐ No c. ☐ Not applicable
5. Was decedent thrown or pushed down? a. ☐ Yes b. ☐ No c. ☐ Unknown

MD 985-3218 (4-93)

CONTINUE ON PAGE 7

PAGE 6

9. ☐ POISONING/OVERDOSE

1. Type of poisoning?

a. ☐ Prescription medicine d. ☐ Illegal drug g. ☐ Food product
b. ☐ Over-the-counter medicine e. ☐ Alcohol h. ☐ Other
c. ☐ Chemical f. ☐ Carbon monoxide or other gas inhalation i. ☐ Unknown

2. Was substance in safety packaging?

a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

3. Location of drug or chemical?

a. ☐ In closed, secured area b. ☐ In closed, unsecured area c. ☐ In open area

10. ☐ FIRE/BURN

1. If fire, the source?

a. ☐ Matches c. ☐ Cigarette e. ☐ Explosives g. ☐ Space heater i. ☐ Other
b. ☐ Lighter d. ☐ Combustibles f. ☐ Fireworks h. ☐ Faulty wiring j. ☐ Unknown

2. Smoke alarm present? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

3. Smoke alarm in working order? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

4. Fire started by? a. ☐ Decedent b. ☐ Other c. ☐ No one d. ☐ Unknown

5. Activity of person starting fire?

a. ☐ Playing c. ☐ Cooking e. ☐ Other g. ☐ Not applicable
b. ☐ Smoking d. ☐ Suspected arson f. ☐ Unknown

6. Construction of fire site?

a. ☐ Wood frame b. ☐ Brick/stone c. ☐ Metal d. ☐ Trailer e. ☐ Other f. ☐ Not applicable

7. Multiple fire injuries or deaths? a. ☐ Yes b. ☐ No

8. For structure fire, where was decedent found?

a. ☐ Hiding b. ☐ In bed c. ☐ Stairway d. ☐ Close to exit e. ☐ Other

9. Did decedent know of a fire escape plan?

a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

10. If burn, the source?

a. ☐ Hot water b. ☐ Appliance c. ☐ Cigarettes d. ☐ Heater e. ☐ Chemical f. ☐ Other

11. ☐ CRUSH (Non-vehicle) (Describe in narrative)

1. Where did crush occur? a. ☐ Indoors b. ☐ Outdoors

12. ☐ CONFINEMENT

1. Place of confinement?

a. ☐ Refrigerator/Appliance c. ☐ Chest/Box/Locker e. ☐ Other
b. ☐ Motor vehicle d. ☐ Room/Building

13. ☐ SHAKEN/IMPACT SYNDROME

1. Prior history of abuse?

a. ☐ Yes b. ☐ No

2. Suspected cause?

a. ☐ Crying b. ☐ Disobedience c. ☐ Feeding difficulty d. ☐ Toilet training e. ☐ Other f. ☐ Unknown

MO 886-3218 (4-99) CONTINUE ON PAGE 8 PAGE 7

14. ☐ **OTHER INFLICTED INJURY**

1. Manner of injury?

a. ☐ Cut/stabbed b. ☐ Struck c. ☐ Thrown d. ☐ Other e. ☐ Unknown

2. Injury inflicted with?

a. ☐ Sharp object (e.g., knife, scissors) c. ☐ Hands/feet e. ☐ Unknown
b. ☐ Blunt object (e.g., hammer, bat) d. ☐ Other

15. ☐ **OTHER CAUSE** (Describe in narrative)

J. NARRATIVE DESCRIPTION OF CIRCUMSTANCES OR OTHER COMMENTS

K. SERVICES PROVIDED

1. List services provided by agencies as a result of the death. (Mark all that apply)

a. ☐ Bereavement counseling d. ☐ Emergency shelter g. ☐ Health care j. ☐ No services
b. ☐ Economic support e. ☐ Mental health services h. ☐ Legal services
c. ☐ Funeral arrangements f. ☐ Social services i. ☐ Other

L. PREVENTION

1. To what degree was this death believed to be preventable?
a. ☐ Not at all b. ☐ Possibly c. ☐ Definitely

2. Primary risk factors involved in the child's death? (Mark all that apply)
a. ☐ Medical c. ☐ Economic e. ☐ Environmental g. ☐ Drugs or alcohol
b. ☐ Social d. ☐ Behavioral f. ☐ Product safety h. ☐ Other

3. Were these risk factors identified in your community prior to the death? a. ☐ Yes b. ☐ No

4. Was any action taken in your community to address the risk factors prior to this death? a. ☐ Yes b. ☐ No

5. Could the family or child have taken actions to reduce the risk? a. ☐ Yes b. ☐ No c. ☐ Unknown

6. What prevention activities have been proposed since the death? (Mark all that apply)
a. ☐ Legislation, law or ordinance f. ☐ Consumer product safety action (800-638-8095)
b. ☐ Community safety project g. ☐ News services
c. ☐ Public forums h. ☐ Changes in agency practice
d. ☐ Educational activities in school i. ☐ Other programs or activities
e. ☐ Educational activities in the media j. ☐ None

7. Target populations for prevention activities? (Mark all that apply)
a. ☐ Children c. ☐ Parents/Care givers e. ☐ Others
b. ☐ General public d. ☐ Child protection professionals

8. Estimated costs for prevention?
a. ☐ No cost involved c. ☐ <$100 e. ☐ >$500
b. ☐ All services donated d. ☐ $100 - $500 f. ☐ Unknown

9. Lead organization?
a. ☐ Health/Medical services d. ☐ Schools g. ☐ Other
b. ☐ Social services e. ☐ Mental health services
c. ☐ Law enforcement f. ☐ Local community group

CFRP CHAIR SIGNATURE ▶ DATE (MM/DD/YY) __/__/__

REGIONAL COORDINATOR SIGNATURE ▶ DATE (MM/DD/YY) __/__/__

MD 566-3216 (4-99) PAGE 8

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CHILD FATALITY REVIEW PANEL (CFRP) FINAL REPORT

TO BE COMPLETED FOR ALL REVIEWABLE CHILD DEATHS LESS THAN 18 YEARS OF AGE

INSTRUCTIONS: Complete the form with all known information and forward to the prevention coordinator within ten days.

IDENTIFICATION INFORMATION

1. DECEDENT'S NAME (FIRST, MI, LAST)

2. SEX
A. ☐ MALE B. ☐ FEMALE

3. DATE OF DEATH ___/___/___

4. DATE OF BIRTH ___/___/___

5. COUNTY OF CFRP PANEL REVIEW

6. DATE OF LAST CFRP PANEL REVIEW ___/___/___

7. CIRCUMSTANCES LEADING TO DEATH? (PRECIPITATING EVENT)

PREVENTION CONCLUSIONS

1. KEEPING IN MIND WHAT IS KNOWN ABOUT THIS TYPE OF FATALITY, IS THERE A PREVENTION MESSAGE?
A. ☐ Yes B. ☐ No

2. IF YES, WHAT PREVENTION MESSAGE(S) ARE APPROPRIATE?

3. HAVE PREVENTION INITIATIVES BEEN DISCUSSED?
A. ☐ Yes B. ☐ No

4. IF YES, WHAT TYPE OF PREVENTION INITIATIVE(S)?

A. ☐ Legislation, Law or Ordinance
B. ☐ Community Safety Project
C. ☐ Public Forums
D. ☐ Educational Activities in School
E. ☐ Educational Activities in the Media
F. ☐ Consumer Product Safety Action (800-638-8095)
G. ☐ News Service
H. ☐ Changes in Agency Practices
I. ☐ Other Programs or Activities

5. BRIEFLY DESCRIBE PREVENTION INITIATIVE(S)

6. ANTICIPATED ORGANIZATIONS INVOLVED?

A. ☐ Health/Medical Services
B. ☐ Social Services
C. ☐ Law Enforcement
D. ☐ Schools
E. ☐ Mental Health Services
F. ☐ Local Community Group
G. ☐ Other

7. TARGET POPULATIONS FOR PROPOSED PREVENTION INITIATIVE(S)?

A. ☐ Children
B. ☐ General Public
C. ☐ Parents/Caregivers
D. ☐ Child Protection Professionals
E. ☐ Other

8. IS STAT PREVENTION COORDINATOR ASSISTANCE REQUESTED CONCERNING CURRENT OR FUTURE PREVENTION INITIATIVES, E.G., FACILITATION, RESOURCES, ETC.?
A. ☐ Yes B. ☐ No

IF YES, POINT OF CONTACT, NAME/TITLE

AGENCY

MAIL/STREET ADDRESS

CITY/STATE/ZIP

PHONE FAX

EMAIL

MO 888-0883 (10-00)

ADDITIONAL COMMENTS/CONCERNS

(Attach extra pages, as necessary)

Send completed Final Report to:

Prevention Coordinator, State Technical Assistance Team
2724 Merchants Drive, Jefferson City, MO 65109
573-751-5980 or 800-487-1626
Fax: 573-751-1479

MO 886-3883 (10-00)

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 45—Records Management

EMERGENCY RULE

15 CSR 30-45.040 Missouri Historical Records Advisory Board (MHRAB) Regrant Program Administration

PURPOSE: This rule outlines the management plan of the grants-in-aid program for historical records preservation.

*EMERGENCY STATEMENT: The Secretary of State finds emergency action of the rule necessary to preserve the compelling governmental interest of enabling the Missouri Historical Records Advisory Board (MHRAB) to apply $300,000 state appropriation and $300,000 federal funds toward a grants-in-aid program to preserve and provide access to Missouri's historic records. The Missouri State Archives' receipt of federal and state funds on behalf of the MHRAB is conditional on accomplishing stated goals and objectives built within the program's start and end dates of January 1, 2001 and June 30, 2003 respectively. The program risks losing funding if the fixed start date of January 1, 2001 is not met. The MHRAB is the central advisory body for historical records planning and for projects relating to historic records, developed and carried out within the state of Missouri. Authority for this rule may be found in RSMo Supp 1999, sections 109.221.3 and 109.221.5. The scope of this emergency rule is limited to circumstances creating the emergency and complies with the protection extended in the **Missouri** and **United States Constitutions**. The Secretary of State believes this emergency rule is fair to all interested parties affected by the circumstances. This emergency rule was filed December 19, 2001, effective January 1, 2001 and will expire June 29, 2001. A proposed rule covering the same material was published in the November 15, 2000 issue of the **Missouri Register**.*

(1) The Missouri Historical Records Advisory Board (MHRAB) Regrant Program, administered by the Missouri State Archives, Office of Secretary of State, with funds provided by the National Historical Publications and Records Commission (NHPRC) and the state of Missouri, grants financial assistance to historical records repositories to enhance the preservation and access of Missouri's documented heritage. This grants-in-aid program is a significant effort in the Missouri Historical Records Advisory Board's mission to promote and support the identification of, preservation of, and access to all historical records in Missouri.

(2) Those eligible to apply include institutions such as historic, ethnic and religious societies; museums; libraries; and colleges and universities whose archival collections or records of historic value are open to the public on equal terms for everyone.

(3) Activities supported by the MHRAB Regrant Program include—

(A) Education;
(B) Planning;
(C) Preservation;
(D) Professional consultants;
(E) Essential equipment;
(F) Reference tools.

(4) Local government entities are ineligible to apply, as the Missouri State Archives Local Records Grant Program (initiated in 1991) offers direct help for records preservation and management to all jurisdictions supported by tax levies.

(5) Ineligible activities include—

(A) Construction, renovation, furnishing, or purchasing a building or land;
(B) Purchasing manuscripts or other historical records;
(C) Conserving or exhibiting archaeological artifacts, museum objects, or works of art;
(D) Undertaking an oral history project unrelated to Native Americans;
(E) Acquiring, preserving, or describing books, periodicals, or other library materials;
(F) Acquiring, preserving, or describing art objects, sheet music, or other works primarily of value as works of art or entertainment;
(G) Undertaking a documentary editing project to publish the papers of someone who has been deceased for less than ten years;
(H) Undertaking a project centered on the papers of an appointed or elected public official who remains in major office, or is politically active, or the majority of whose papers have not yet been accessioned in a repository;
(I) Processing documents, a major portion of which will be closed to researchers for more than five years, or not be accessible to all users on equal terms, or will be in a repository that denies public access;
(J) Undertaking an arrangement, description, or preservation project in which the pertinent documents are privately owned or deposited in an institution subject to withdrawal upon demand for reasons other than requirements of law;
(K) Undertaking an arrangement, description, or preservation project involving federal government records that are—

1. In the custody of the National Archives and Records Administration (NARA); or
2. In the custody of some other federal agency; or
3. Have been deposited in a non-federal institution without an agreement authorized by NARA. Note: Many federally funded activities not directly undertaken by the federal government produce documents that may in law be considered federal records, including records produced under federal contracts or grants. If your project deals with federal records, you should talk further with the Archives Grant Administrator;

(L) Funding for—

1. Existing/permanent staff positions;
2. Equipment nonessential to the project;
3. Payments to lobbyists;
4. Hospitality expenses;
5. Prizes/awards;
6. Benefit activities such as socials, fundraisers, etc.;
7. Educational outreach not available to the public;
8. Activities having a religious purpose;
9. Expenses incurred prior to the grant period.

(6) Funding.

(A) The MHRAB Regrant Program supports 100% of the total costs for projects between $500 and $5,000.
(B) For projects over $5,000 the MHRAB Regrant Program supports 70% of the project and the applicant must contribute a minimum of 30% in cost-sharing match with 10% of the total project cost in local cash match.
(C) An in-kind contribution may consist of staff time, supplies, utilities (if local space is required for the project), donated to the project.
(D) Permanent equipment is a separate line item requiring a 50/50 match of grant funds and local cash.
(E) Applicants that have a higher percentage of cash cost-sharing will be given preference when all other things are equal.
(F) The maximum grant that can be requested is $25,000 per application.

(7) Grant Application Requirements.

(A) Identification of entity, entity's governance structure and project personnel.

(B) Activity description—

1. Statement of purpose and goals;
2. Project summary;
3. Detailed analysis of plan, discussion of techniques and timeline of activities;
4. Project objectives;
5. Specific end results or products.

(C) Funding description—

1. Budget layout;
2. Budget explanation;
3. Need for outside funding;
4. Local entity's accounting methods and audit procedures.

(D) Relevant information—

1. Statement of any previous relevant actions;
2. Evaluation of results (how will the success or failure be measured);
3. Description of importance of the project in terms of an overall, long-range program.

(E) Authorization—

1. Signed and dated by proper official;
2. Identification of preparer of the application.

(F) Support material—

1. Letter of commitment from the applicant's funding authority;
2. Resumes of project personnel, consultants, volunteers, and descriptions of their grant-funded duties;
3. Required forms;
4. Appropriate attachments, such as floor plans, sample forms, letters of support;
5. Identification of necessary services, equipment, supplies;
6. Other relevant information.

(8) Evaluation of Proposals.

(A) The Archives Grant Administrator will review grant applications for completeness; conformity to application requirements; soundness of budget; and relevancy to the objectives of the MHRAB Regrant Program.

(B) Each complete application will be summarized and forwarded to the MHRAB.

(C) The MHRAB will evaluate applications based on the following criteria—

1. Demonstrated need for outside funding;
2. Commitment to professional practices;
3. Historical value of records;
4. Ability to maintain achievements.

(D) The MHRAB will make funding decisions at meetings set for this purpose.

(E) The Archives Grant Administrator will notify the applicant on behalf of the MHRAB in writing if the proposal has been funded or rejected.

(9) Grant Calendar.

(A) The first grant period will begin in September 2001 and the second in March 2002; both will close December 31, 2002. Award letters will be issued by the Archives Grant Administrator, Office of Secretary of State.

(B) The first payment in the grant award will not accompany the official award letter, but should be received by the end of the first month in each grant cycle. Subsequent payments are contingent upon receipt by the Archives Grant Administrator of complete and accurate Interim Reports submitted by the grantee.

(C) Grant work must be monitored while in progress. Archives staff may visit the work site for review at any time during the grant cycle.

(D) Any changes in the project, including changes of personnel, must be submitted in writing to the Archives Grant Administrator, Office of Secretary of State.

(E) The grantee must submit Final Reports within 30 days of the grant cycle's conclusion. Report forms will be provided to the grantee. Final Reports should relate to the original grant proposal and evaluate the progress made in accomplishing stated goals and objectives. Failure to comply may negatively impact the organization's ability to obtain future grants.

(F) Grant projects must be completed during the grant period. One extension may be requested in writing to the Archives Grant Administrator, Office of Secretary of State. The request must relate the extenuating circumstances hindering completion of the grant project. If an extension is granted, notification will be made in writing by the Archives Grant Administrator, Office of Secretary of State. A request for extension must be made by August 2002. If the extension is not approved, the award may be canceled.

(10) Accounting.

(A) Grantees must keep financial records for each grant in accordance with agreed upon accounting practices. These records, as public records, shall be subject to inspection by Secretary of State staff and members of the MHRAB during regular business hours throughout the grant period and for the following three years after the grant period ends. If any litigation, claim, or audit is begun before the end of the three years, the records must be retained until such proceeding is resolved.

(B) Grant money must be deposited in an auditable, interest-bearing account, and interest received must be applied to the project.

(C) While the grantee cannot invoice expenses incurred before the grant period begins, expenses incurred after the grant period begins but before the monies are available are allowable.

(D) Grantees must submit documentation for in-kind contributions with Interim and Final Reports. Grantees must submit bid information for services or purchases over $3,000 with Interim and Final Reports.

(E) All unused grant funds and interest in possession of the grantee must be returned to the MHRAB Regrant Program.

(F) In the case of default by the grantee, the grant will be revoked and all unused funds must be returned to the MHRAB Regrant Program. The Archives Grant Administrator will notify the grantee of default in writing.

(11) Auditing Requirements. The grantee is responsible for ensuring that the MHRAB receives copies of the audit report for any audit performed during the grant period or for the following three years.

(12) Conflicts of Interest.

(A) An MHRAB member shall abstain from reviewing or voting on proposals if s/he is indirectly connected with a proposed project through employment at the same institution, indirectly supervises the project, serves as an unpaid consultant to the project, or is an officer of the institution or association that submits the proposal. Nor may the board member be physically present during board discussion of such a proposal.

(B) An MHRAB member may participate in discussion of, but not vote on, a grant proposal if s/he merely subscribes to membership in the organization submitting the proposal, but holds no office.

AUTHORITY: sections 109.221.3 and 109.221.5, RSMo 2000. Original rule filed Oct. 6, 2000. Emergency rule filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.010 Definitions. This rule established the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) When used in this plan document, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12) month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions (22 CSR 10-2.040), (22 CSR 10-2.045), (22 CSR 10-2.050), (22 CSR 10-2.055), (22 CSR 10-2.060), (22 CSR 10-2.063), (22 CSR 10-2.064), (22 CSR 10-2.065), and (22 CSR 10-2.066) as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the PPO and co-pay plans;

(I) Co-pay plan—A set of benefits similar to the premium option. Co-payment amounts are generally an average of those for the premium and standard options;

(J) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(K) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(L) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(M) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in this plan document, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation immediately.

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the preferred provider organization (PPO) plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the PPO plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning;

4. Married; or

5. Not dependent upon parents or guardian for at least fifty percent (50%) support;

(Q) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)9.;

(R) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(S) Employees—Employees of the state and other public entities and present and future retirees from state and other public entity employment who meet the eligibility requirements as prescribed by state law or other public entity who have applied and have been accepted for membership in the plan;

(T) Executive director—The administrator of the Missouri Consolidated Health Care Plan who reports directly to the plan administrator;

(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(V) Home health agency—An agency certified by the Missouri Department of Health, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(W) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(X) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(X)1., but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Y) Lifetime—The period of time you or your eligible dependents participate in the plan;

(Z) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(AA) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(BB) Medicare HMO (risk contract)—An HMO exclusively for members residing in specified areas and covered by Medicare whereby benefits are provided in accordance with a plan approved by federal regulation;

(CC) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(DD) Open enrollment period—A period designated by the plan during which members may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(EE) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(FF) Out-of-network—Providers that do not participate in the member's health plan;

(GG) Participant—Any employee or dependent who has been accepted for membership in the plan;

(HH) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(II) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under 334.021, RSMo;

(JJ) Plan—The program of medical care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(KK) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(LL) Plan document—This statement of the terms and conditions of the plan as adopted by the plan administrator;

(MM) Plan year—Same as benefit year;

(NN) Point-of-service—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(OO) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(PP) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(QQ) Premium option—A set of covered benefits with specified co-payment and coinsurance amounts;

(RR) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(SS) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(TT) Public entity—A state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board;

(UU) Review agency—A company responsible for administration of clinical management programs;

(VV) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(WW) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(VV) which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(XX) Staff model—A set of covered benefits established by the HMO similar to the premium and standard options, but with varying co-payment and coinsurance amounts;

(YY) Standard option—A set of covered benefits similar to the premium option, but with higher co-payment and co-insurance amounts;

(ZZ) State—Missouri;

(AAA) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. This child(ren) must rely on the parent/custodian for his/her major financial support (appropriate documentation may be required). Except for a disabled child(ren) as described in subsection (1)(GG), an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-2.020(5)(D)2. for continuing coverage on handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan; and

(BBB) Usual, customary, and reasonable charge.

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.020 Membership Agreement and Participation Period. This rule established the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect

*changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed March 17, 1997, effective July 1, 1997, expired Sept. 22, 1997. Amended: Filed March 17, 1997, effective Aug. 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 18, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.020 Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) The application packet and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP a public entity agrees that—

1. For groups of less than five hundred (500) employees, the MCHCP will be the only health care offering made to its eligible members. For groups of five hundred (500) or more employees the entity may maintain a self-insured preferred provider organization (PPO) plan or one point-of-service (POS) option (either self-insured or on a fully-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP (also see number (1)(A)8.);

2. It will contribute at least twenty-five dollars ($25) per month toward each active employee's premium;

3. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the PPO options. Appropriate proof of said deductibles will be required;

4. Eligible members joining the MCHCP who were covered by any medical plan offered by the public entity or an individual policy will not be subject to any preexisting condition;

5. Eligible members joining the MCHCP at the time of the initial eligibility of the public entity will not have to prove insurability;

6. For groups contracting only with the MCHCP, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For groups of five hundred (500) employees or more that choose one of the alternative options identified in paragraph (1)(A)1., the entity must maintain seventy-five percent (75%) coverage of all their employees covered through all of their offerings;

7. An eligible employee is one that is not covered by another group sponsored plan;

8. Public entities joining the plan must offer their eligible members all the plans available through the MCHCP;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) Effective January 1, 2001, in order to provide retiree coverage, any participating member agency joining MCHCP must have one of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employee Retirement (MOSERS). If this criterion

was not met, the employer may not offer coverage to that person as a retiree.

(2) The employee membership agreement shall consist of the written application of the employee, the plan document as adopted by the board and duly executed amendments. The plan booklets and any associated administrative guidelines interpret the membership agreement for the benefit of members and administrators but are not a part of the membership agreement.

(3) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan.

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event.

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided;

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is not eligible for coverage until the next open enrollment period; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan.)

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity.

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees or long-term disability recipients covered under the plan.)

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(5) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (6) and (7).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (7).

(6) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(7) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible.

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible.

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, long-term disability recipients and their dependents are not later eligible if they discontinue their coverage at some future time.

(C) Coverage at Termination—A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence—An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to HMO or POS members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form.

(E) Layoff—An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation—Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal—If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator

is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the rate under the regular PPO plan, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(9) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) you continue and maintain coverage under the thirty-six (36)-month provision of COBRA, and b) you are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.040 Indemnity Plan Summary of Medical Benefits. This rule established the policy of the board of trustees in regard to medical benefits for participants in the Missouri Consolidated Health Care Plan Indemnity Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, terminated Feb. 18, 2000. Emergency amendment filed Feb. 8, 2000, effective Feb. 18, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.040 PPO Plan Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan PPO.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Lifetime maximum, three million dollars ($3,000,000).

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5000).

(3) Deductible Amount—Per individual for the preferred provider organization (PPO) plan each calendar year, three hundred dollars ($300), family limit each calendar year, nine hundred dollars ($900).

(4) Coinsurance.

(A) Individual:

1. PPO—Ninety percent (90%) of the first seven thousand five hundred dollars ($7500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

2. Non-network—Seventy percent (70%) of the first seven thousand five hundred dollars ($7500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

3. Out-of-area—Eighty percent (80%) of the first seven thousand five hundred dollars ($7500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

(B) Family:

1. PPO—Ninety percent (90%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

2. Non-network—Seventy percent (70%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

3. Out-of-area—Eighty percent (80%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

(5) The deductible will be waived and the employee or dependent will only be responsible for a ten dollar ($10) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator. Charges for other covered services provided in addition to the office visit will be covered under the regular PPO benefit(s) available at the time of service.

(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.

(7) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (7)(A) and (B) may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

(8) Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(9) Prescription Drug Program—The PPO plan provides coverage for maintenance and non-maintenance medications, as described in the following:

(A) Medications.

1. In-Network.

A. Five dollar ($5) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

2. Non-Network—The deductible will apply. After satisfaction of the deductible, claims will be paid at fifty percent (50%) coinsurance. Charges will not be applied to the out-of-pocket maximum.

3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment for a drug on the maintenance list.

(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable

deductibles or coinsurance. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.045 Co-Pay Plan Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Lifetime Maximum:

(A) Network— no limit.

(B) Out-of Network, Out-of-Area—three million dollars ($3,000,000).

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5000).

(3) Non-Network and Out-of-Area Deductible Amount—

(A) Network—zero ($0).

(B) Out-of-Network, Out-of-Area—three hundred dollars ($300) individual, nine hundred dollars ($900) family, per calendar year.

(4) Coinsurance.

(A) Individual—

1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the two thousand dollar ($2000) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.

2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the four thousand five hundred dollar ($4500) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying one thousand five hundred dollar ($1500) individual out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

(B) Family—

1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the six thousand dollar ($6000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.

2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the nine thousand dollar ($9000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

3. Out-of-area—Eighty percent (80%) co-insurance applies to covered services after satisfying three thousand dollar ($3000) family out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

(C) Non-Network Services—Same as subsections (4)(A) and (B), except covered charges are reimbursed on a seventy percent (70%) basis.

(5) The employee or dependent will only be responsible for a fifteen dollar ($15) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator.

(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.

(7) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan.

These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (7)(A) and (B) may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

(8) Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(9) Prescription Drug Program—The co-pay plan provides coverage for maintenance and non-maintenance medications, as described in the following:

(A) Medications.

1. In-Network.

A. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

2. Non-Network—The deductible will apply. After satisfaction of the deductible, claims will be paid at fifty percent (50%) coinsurance. Charges will not be applied to the out-of-pocket maximum.

3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment for a drug on the maintenance list.

(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable deductibles or co-insurance. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.050 Indemnity Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Indemnity Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.050 PPO Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan PPO Plan.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri

Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Benefit Provisions.

(A) Subject to the provisions and limitations of this plan document and the written application of the employee, the benefits, as provided in the summary of benefits, are payable for covered charges incurred by a participant while covered for this benefit, provided the deductible requirement, if any, is met.

(B) The deductible requirement applies each calendar year to covered charges shown in the summary of benefits. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount shown in the summary of benefits.

(C) The family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement shown in the summary of benefits.

(D) The total amount of benefits payable for all covered charges incurred during an individual's lifetime shall not exceed the lifetime maximum specified in the summary of benefits, subject to reinstatement as provided in subsections (1)(E) and (F).

(E) An annual reinstatement of benefits previously paid will be made on each January 1 for each insured person, not to exceed the automatic annual reinstatement maximum on the summary of benefits. In no event will the reinstatement increase the lifetime maximum to an amount in excess of the lifetime maximum shown in the summary of benefits.

(F) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) Only charges for those services listed in this rule which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service, and which are—a) prescribed by a doctor or provider for the therapeutic treatment of injury or sickness; b) to the extent they don't exceed any limitation; c) not excluded by the limitations; and d) for not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following: a) the medical benefits or supplies usually rendered or prescribed for the condition; and b) the usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) Covered charges are divided into mutually exclusive types and each covered charge shall be deemed to be covered on the date the medical benefit, service or supply is received.

1. Type A charges for hospital daily room and board and routine nursing. The maximum covered charge for a private room is the hospital's most common semi-private room rate unless a private room is recommended by a physician and approved by the claims administrator or the plan's medical review agency.

2. Type B charges for intensive care, concentrated care, coronary care or other special hospital unit designed to provide special care for critically ill or injured patients.

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are conducted and which are necessary for hospital admission and which are not duplicated for screening purposes upon admission to the hospital.

4. Type D special hospital charges for inpatient medical care and supplies received during any period room and board charges are made except—

A. Those included in paragraphs (2)(C)1.–3.; and

B. Special nursing care.

5. Type E charges for outpatient medical care or supplies.

6. Type F surgery and anesthesia charges of a provider for the giving of anesthesia not included in paragraphs (2)(C)4. and 5.

7. Type G psychiatric service charges of a provider licensed to provide services which relate to care of mental conditions.

8. Type H professional service charges not included in paragraphs (2)(C)2.–7. made by a provider or by a laboratory for diagnostic laboratory and X-ray exams.

9. Type I nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on his/her own behalf.

10. Type J professional service charges of a licensed physical therapist, occupational therapist, audiologist or respiratory therapist, subject to medical necessity review by claims administrator.

11. Type K transportation charges not included in paragraphs (2)(C)3. and 4. for professional air or ground ambulance services for local transportation to and from a hospital, from a hospital to and from a local facility which provides specialized testing or treatment or from a hospital to a skilled nursing facility and charges for travel within the United States by a scheduled railroad, airline or ambulatory carrier to, but not back from, the nearest hospital equipped to furnish needed special treatment.

12. Type L charges for orthopedic or prosthetic devices and hospital-type equipment not included in paragraphs (2)(C)4. and 5. for—

A. Man-made limbs or eyes for the replacing of natural limbs or eyes;

B. Casts, splints or crutches;

C. Purchase of a truss or brace as a direct result of—

(I) An injury or sickness which began while covered under these rules; or

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair or scooter (manual or powered) or hospital equipment to aid in breathing;

E. Dialysis equipment rental, supplies, upkeep and the training of the participant or an attendant to run the equipment;

F. Colostomy bags and ureterostomy bags;

G. Bilateral hearing aids; and

H. Augmentative communication devices.

13. Type M charges for prescription drugs from a licensed pharmacist; or for anesthesia when given by a provider if not included in paragraphs (2)(C)3.–6.

14. Type N charges for skilled nursing care including room and board when the stay is medically necessary, as determined by the claims administrator.

15. Type O charges for the services of a licensed speech therapist if the charges are made for speech therapy used for the purpose of correcting speech loss or damage which—

A. Is due to a sickness or injury, other than a functional nervous disorder or surgery due to such sickness or injury; or

B. Follows surgery to correct a birth defect.

16. Type P charges for services and supplies from a home health care agency which are medically necessary, as determined by the claims administrator.

17. Type Q charges for outpatient treatment of mental and nervous conditions.

18. Type R charges for outpatient treatment chemical dependency.

19. Type S charges for hospice services.

20. Type T charges for education and training if it will promote the patient to a lower level of medical/nursing care.

21. Type U charges for surgical and medical procedures performed by a podiatrist.

22. Type V charges for transplants.

23. Type W charges for services rendered by a physician or other provider.

24. Type X charges for normally covered services arising from a non-covered service.

25. Type Y charges for Internet Physician Visits when enrolled in the Care Support Program and registered for the service.

(D) If covered charges provide for rental of durable equipment and the participant's condition is such that use of the equipment is projected for a period of time to make purchase of the equipment less costly than rental, then with the advanced authorization by the claims administrator or his/her designee, the equipment may be purchased and the purchase price will be considered a covered charge. At the option of the claims administrator, or his/her designee, durable equipment may be purchased based on quality and cost considerations. Maintenance and repair of purchased equipment is covered if provider supplies statement of continued medical necessity in time intervals determined by claims administrator or his/her designee.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.055 Co-Pay Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-pay Plan.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Covered Charges.

(A) Allergy Injections—Fifteen dollar ($15) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered with fifty dollar ($50) co-payment if medically necessary or with prior approval. Air services covered on same basis, twenty percent (20%) coinsurance and deductible for non-emergencies.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%). Not covered out-of-network.

(D) Chiropractic Benefits—Charges subject to fifteen dollar ($15) co-payment; fifty dollar ($50) co-pay per visit maximum, two thousand dollar ($2000) annual maximum (out-of-network only).

(E) Complications—Normally covered charges arising as a complication of a non-covered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services that are a result of that injury. Fifteen dollar ($15) office visit co-pay, regardless of where services are rendered.

(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a fifteen dollar ($15) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance, medical necessity and prior authorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and fifteen dollar ($15) co-payment for annual hearing test.

(L) Home Health Care—Covered when authorized by claims administrator.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be pre-certified.

(O) Hospital Benefits for Chemical Dependency—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be pre-certified.

(P) Hospital Room and Board—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual maximum. Must be pre-certified.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Not covered out-of-network. Deductible applies to out-of-area.

(S) Maternity Coverage—Fifteen dollar ($15) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Nutrient Supplement—Not covered out-of-network.

(U) Organ Transplants—The following organ transplants covered at one hundred percent (100%) through the National Transplant Program: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by the claims administrator. Donor expenses are covered. No waiting periods allowed. Non-network and out-of-area limited to maximum surgical schedule.

(V) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(W) Outpatient Mental and Nervous Disorder and Chemical Dependency—Fifteen dollar ($15) co-payment per visit.

(X) Oxygen—(Outpatient) Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(Y) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits if medically necessary.

(Z) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after fifteen dollar ($15) co-payment per office visit.

3. Internet—Covered when enrolled in the Care Support Program and registered for the service.

(AA) Plan Maximum—Not applicable for network services, out-of-network and out-of-area limited to three (3) million dollars with five thousand ($5000) reinstatement.

(BB) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

A. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five ($25) co-pay for thirty (30)-day supply for non-formulary drug.

D. Ninety (90)-day supply of maintenance medication for two (2) co-payments (mail order only).

(CC) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well woman exam without referral to a network provider.

(DD) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition.

(EE) Skilled Nursing—Provided in full. Limited to one hundred and twenty (120) days.

(FF) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Fifty dollar ($50) co-payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.060 Indemnity Plan Limitations. This rule established the policy of the board of trustees in regard to limitations in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1997, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.060 PPO and Co-Pay Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan PPO Plan and Co-Pay Plan.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) If applicable, all hospitalizations, out-patient treatment for chemical dependency or mental and nervous disorder are not precertified as described in 22 CSR 10-2.040(7)(A), reimbursement will be reduced by ten percent (10%) of reasonable and customary charges;

(B) Blood or plasma to the extent a refund or credit is made as a result of operation of a group blood bank or otherwise;

(C) Cosmetic, plastic, reconstructive or restorative surgery performed for the purpose of improving appearance unless such expenses are incurred for repair of a disfigurement caused from any of the following:

1. An accidental injury which was sustained while covered under these rules;

2. A sickness first manifested while covered under these rules;

3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least six (6) months; or

4. A birth defect; or

5. Mastectomies;

(D) Hearing aids once every two (2) years and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery which is performed while covered under these rules);

(E) Injury or sickness resulting from—

1. Act of war (declared or undeclared);

2. Insurrection; or

3. Atomic explosion or other release of nuclear energy under any condition except when used solely as medical treatment;

(F) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one of its agencies; or

2. Any state's cash sickness or similar law including any group insurance policy approved under such law;

(G) Medical care and supplies for which—

1. No charge is made;

2. The member or dependent is not required to pay, including but not limited to, any portion of any charges that are discounted; and

3. Charges exceed the usual, customary and reasonable rate (does not apply to network services for preferred provider organization (PPO) or co-pay plan);

(H) Injury or sickness resulting from taking part in the commission of a felony;

(I) Sickness or injury covered by Workers' Compensation, occupational disease law or similar laws, or injury if it arises out of any employment for pay, profit or gain and is covered by one of the former programs including all charges to be covered by any associated settlement agreement;

(J) Charges made with respect to a participant, but which are incurred due to the injury or sickness of a different person who is not a participant in this plan;

(K) Oral care and supplies which are used to change vertical dimension or closure, including, but not limited to:

1. Procedures used for diagnosis;

2. Procedures used for balance;

3. Restoration;

4. Fixed devices; and

5. Movable devices;

(L) Any treatment or examination of teeth or nerves connected to teeth except—

1. Extraction of bony and partial bony impactions (not covered by co-pay plan); and

2. Treatment or examination of injuries to sound and natural teeth sustained in an accident while covered under the rule, or such treatment received after the patient has been covered under the plan for at least twelve (12) consecutive months; and provided the injury/illness was incurred within one (1) year of the effective date of coverage;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following, regardless of whether or not prescribed by a physician or provider:

1. Experimental/investigational procedures, as defined in the claims administrator's guidelines;

2. Exercise for the eyes;

3. Psychological testing;

4. Nerve stimulators with the exception of transcutaneous electrical nerve stimulator (TENS) units;

5. Any treatment of obesity due solely to overeating;

6. Custodial care;

7. Gamete intrafallopian transfer/zygote intrafallopian transfer (GIFT/ZIFT);

8. Travel (see (1)(CC)), lodging (see (1)(CC)), recreation or exercise;

9. Air conditioners, purifiers or humidifiers;

10. Nonprescription drug items (except insulin and other diabetic supplies); and

11. Acupuncture, acupressure, and biofeedback;

(N) Trimming of corns, calluses and toenails unless the participant is a diabetic, has a peripheral vascular disease or is blind;

(O) Foot support unless custom-made to fit the participant's foot and prescribed by a physician;

(P) Abortion except when two (2) physicians have found and so certified in writing to the claims administrator that, on the basis of their professional judgment, the life of the mother would be endangered if the fetus were carried to term or that medical complications have arisen from a previous abortion.

1. The certification must contain a diagnosis of the disease, the clinical effect of the pregnancy on the disease with the physician's prognosis of the health of the patient as affected if the fetus were carried to term, the name and address of the patient and the names of any physicians or providers previously consulted by the patient with regard to the disease and the pregnancy;

2. At least one (1) of the two (2) physicians must also certify that s/he is not an interested physician. For purposes in this rule, an interested physician is one—

A. Whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or

B. Who is the spouse or another relative who lives with a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion;

(Q) Preexisting conditions, except charges incurred after the individual has been a participant for six (6) consecutive months. A preexisting condition is one for which medical care was received or prescribed drugs were taken, or for which expenses were incurred during the three (3) months prior to the participant's effective date. This limitation does not apply to participants transferred from another plan as provided in 22 CSR 10-2.010 (1)(O)2. or 22 CSR 10-2.020(1)(A)4.

1. Exceptions to preexisting conditions.

A. If the member had previous coverage and the break in coverage was less than sixty-three (63) days, the preexisting limitations will be reduced by the time covered under the previous plan; and

B. Preexisting limitations do not apply to:

(I) Members enrolled in a separate plan through Missouri Consolidated Health Care Plan (MCHCP) for the preceding six (6) months; or

(II) Pregnancies, newborn children, or children placed for adoption;

(R) Chemical dependency and mental and nervous disorder treatments in PPO plan are limited to:

1. Network provider.

A. First five (5) visits paid with a ten dollar ($10) co-payment;

B. Visits six (6) through ten (10) with a fifteen dollar ($15) co-payment;

C. Additional visits paid with a twenty dollar ($20) co-payment; and

D. Outpatient hospital services subject to deductible and ten percent (10%) coinsurance;

2. Non-network provider—Subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

(S) Outpatient chemical dependency and mental and nervous disorder treatments in the co-pay plan are limited to:

1. Network provider.

A. Fifteen dollar ($15) co-payment for office visits;

B. Outpatient hospital services covered at one hundred percent (100%);

2. Non-network provider—Subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

(T) Marital and family counseling for group or individual psychotherapy;

(U) Chiropractic services are limited to a maximum allowable charge of fifty dollars ($50) per visit, and a two thousand dollar ($2000) total annual maximum. Diagnostic lab and X-ray services are not included in the fifty dollar ($50) maximum per visit, but are included in the two thousand dollar ($2000) total annual maximum. In-network office visits in the co-pay plan are subject to a fifteen dollar ($15) co-payment;

(V) Associated charges for non-covered services;

(W) Any services not specifically included as a covered benefit;

(X) Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B_{12} shots, and certain vitamin therapies as determined by the claims administrator;

(Y) Treatment of temporal mandibular joint dysfunction (TMJ) not covered unless approved by claims administrator;

(Z) Reversals of tubal ligations and vasectomies;

(AA) X-ray and office charges associated with flat feet;

(BB) Preferred Provider Organization (PPO) Office Visit Co-Payments;

(CC) Transplants are limited to heart, lung, liver, kidney, cornea, bone marrow, pancreas and intestinal, and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines;

Benefits are allowed in accordance with the following schedule:

Benefit Description	The First Health National Transplant Program	First Health Network (PPO) Hospital	Non-PPO Hospital	Additional Limitations and Explanations
Plan Pays	100%	90% of NTP fees	70% of NTP fees	Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (under age 19, both parents). The plan's co-payment will be reduced by 10% when not using The First Health National Transplant Program if you do not follow the procedures required by the clinical management services program. This penalty and your non-PPO coinsurance do not apply to the out-of-pocket maximum.
Annual Deductible	NO	YES	YES	
Organ Donor Costs Per Transplant	Unlimited	$10,000	$10,000	
Travel, Lodging And Meals Allowance Per Transplant	$10,000	None	None	
Lifetime benefit Maximum	Subject to Plan Maximum	Subject to Plan Maximum	Subject to Plan Maximum	

1. Cornea transplant covered under surgical benefit;

(DD) In addition to any other listed limitations, out-of-network services in the PPO and co-pay plans are subject to the deductible and seventy/thirty percent (70%/30%) coinsurance out-of-network, eighty/twenty percent (80%/20%);

(EE) Skilled nursing charges limited to one hundred twenty (120) days per calendar year;

(FF) *In vivo* artificial insemination subject to deductible (not applicable in co-pay plan) and fifty percent (50%) coinsurance, which does not apply to the out-of-pocket maximum. Not covered out-of-network;

(GG) Eye refractions limited to one annually and only if provided in the network;

(HH) Treatment of nearsightedness, farsightedness and astigmatism; and

(II) Physician Internet Visits are limited to twenty-four (24) visits per year and a $600 annual maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.063 HMO/POS/POS98 Summary of Medical Benefits. This rule established the policy of the board of trustees regarding the HMO/POS/POS98 summary of medical benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Emergency amendment filed Feb. 23, 1998, effective March 5, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Premium Plans.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Covered Charges.

(A) Allergy Injections—Ten dollar ($10) co-payment for office visit also covers injection. Five dollar ($5) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to ten dollar ($10) co-payment.

2. POS—Out-of-network coverage subject to deductible and coinsurance with the same limitations as under the PPO plan.

(E) Complications—Normally covered charges arising as a complication of a noncovered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services as a result of that injury.

(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a ten dollar ($10) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) co-insurance. Subject to medical necessity and authorization by HMO or POS.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and ten dollar ($10) co-payment for annual hearing test. POS out-of-network not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefits for Mental and Nervous Disorder—Provided in full with proper authorization.

(O) Hospital Benefits for Chemical Dependency—Same as for mental and nervous above.

(P) Hospital Room and Board—Provided in full. Must be arranged by HMO or POS physician.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). POS out-of-network not covered.

(S) Maternity Coverage—Ten dollar ($10) co-payment for initial visit. All other prenatal visits, delivery costs and routine postnatal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS out-of-network limited to in-network rates.

(U) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(V) Outpatient Mental and Nervous Disorder—Ten dollar ($10) co-payment per visit. Deductible and coinsurance do not apply to out-of-pocket maximum for out-of-network services. POS out-of-network limited to twenty-six (26) visits per calendar year.

(W) Oxygen (Outpatient)—Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Five dollar ($5) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits subject to medical review.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar ($10) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to three (3) million dollars with five thousand dollar ($5,000) annual reinstatement.

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

A. Five dollar ($5) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

D. Ninety (90)-day supply of maintenance medication for two (2) co-payments through mail order.

(BB) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well woman exam without referral to a network provider.

(CC) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition or growth. Repair or replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired August 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.064 HMO/POS Standard Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Standard Plans.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri***

*and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Covered Charges.

(A) Allergy Injections—Twenty dollar ($20) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to twenty ($20) co-payment.

2. POS—Out-of-network services not covered.

(E) Complications—Normally covered charges arising as a complication of a noncovered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restoration as a result of that injury.

(G) Durable Medical Equipment—Thirty percent (30%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a twenty dollar ($20) co-payment.

(J) Growth Hormone Therapy—Thirty percent (30%) coinsurance. Subject to medical necessity and preauthorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to thirty percent (30%) co-payment and thirty dollar ($30) co-payment for annual hearing test. POS non-network services not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization.

(O) Hospital Benefits for Chemical Dependency—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(P) Hospital Room and Board—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Not covered.

(S) Maternity Coverage—Twenty dollar ($20) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS out-of-network not covered.

(U) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(V) Outpatient Mental and Nervous Disorder—Twenty dollar ($20) co-payment per visit. POS out-of-network services not covered.

(W) Oxygen (Outpatient)—Subject to thirty percent (30%) coinsurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits are subject to medical review.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after twenty dollar ($20) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to one (1) million dollars ($1,000,000).

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty dollar ($30) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of maintenance medication for two (2) co-payments.

(BB) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well woman exam without referral to a network provider.

(CC) Prosthetics—Provided in full for initial placement. Thirty percent (30%) coinsurance for coverage for repair or replacement due to change in medical condition. Repair and replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

*AUTHORITY. section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.065 Staff Model Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan Staff Model.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri

Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Covered Charges.

(A) Allergy Injections—Ten dollar ($10) (Premium) and twenty dollar ($20) (standard) co-payment for office visit also covers injection.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%).

(D) Chiropractic Benefits.

1. Health maintenance organization—(HMO) in-network—Charges subject to co-payment; ten dollars ($10) (premium), twenty dollars ($20) (standard).

(E) Dental Care—Treatment to reduce trauma as a result of accidental injury and restoration as a result of that injury. Fifty percent (50%) coinsurance. One thousand dollar ($1000) maximum per incident.

(F) Durable Medical Equipment—Provided in full (premium); Twenty percent (20%) coinsurance (standard). Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(G) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(H) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a ten dollar ($10) co-payment (premium); twenty dollar ($20) co-payment (standard).

(I) Hearing Aids and Testing—Covered once every three (3) years, subject to twenty percent (20%) co-payment and ten dollar ($10) co-payment for annual hearing test (premium); twenty dollar ($20) co-payment (standard).

(J) Home Health Care—Covered when authorized by HMO physician.

(K) Hospice Care—Covered in full with proper authorization.

(L) Hospital Benefit for Mental and Nervous Disorder—Covered in full (premium). Two hundred dollar ($200) co-payment per admission with six hundred dollar ($600) annual maximum (standard). Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization.

(M) Hospital Benefits for Chemical Dependency—Limited to sixty (60) days annually (premium). Same as mental health, but limited to forty-five (45) days annually (standard).

(N) Hospital Room and Board—Provided in full (premium). Two hundred and fifty dollar ($250) co-payment per admission with seven hundred and fifty dollar ($750) annual inpatient hospital maximum (standard).

(O) Injections—All injections (except allergy and contraceptive injections) ten dollars ($10) (premium), twenty dollars ($20) (standard), co-payment.

(P) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) (premium). Not covered in standard plan.

(Q) Maternity Coverage—Provided in full.

(R) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO. Donor expenses are covered as long as the patient is a member of the HMO. No waiting periods allowed.

(S) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(T) Outpatient Mental and Nervous Disorder—Ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment per office visit. Ten dollar ($10) (premium), fifteen dollar ($15) (standard), co-payment for chemical dependency visits. Limited to forty (40) visits for chemical dependency per calendar year.

(U) Oxygen—(Outpatient) Provided in full.

(V) Physical Therapy and Rehabilitation Services—Ten dollar ($10) (premium), twenty dollar ($20) (standard) co-payment per visit for outpatient therapy. Limited to sixty (60) visits. Additional visits when medically necessary.

(W) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment per office visit.

(X) Plan Maximum—Not applicable.

(Y) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug. Non-formulary drugs not covered.

1. Ten dollar ($10) (premium), twenty dollars ($20) (standard), co-pay for thirty (30) day supply for generic drug on the formulary.

2. Non-formulary drugs not covered.

3. Sixty (60) day supply of maintenance medication for two dollar ($2) mailing fee and twenty dollar ($20) (premium), forty dollar ($40) (standard), co-payment.

(Z) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well woman exam without referral to a network provider. Provided in full.

(AA) Prosthetics—Covered in full (premium), twenty percent (20%) coinsurance (standard).

(BB) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—fifty dollar ($50) co-payment.

(CC) Complications—Normally covered charges arising as a complication of a non-covered service.

(DD) Growth Hormone Therapy—Subject to plan authorization and ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment.

(EE) Skilled Nursing—Covered in full and limited to 100 days annually.

(FF) Medicare HMOs (risk contracts) will provide benefits as specified in their contract and will be administered in accordance with all applicable federal statutes and regulations.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A

*proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.067 HMO and POS Limitations. This rule established the policy of the board of trustees regarding the HMO and POS limitations under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.067 Staff Model, HMO and POS Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan Staff Model and HMO/POS Plans.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Benefits shall not be payable for, or in connection with, any medical benefit, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) Abortion services limited to situations when the life of the mother is endangered if the fetus is carried to term or due to the nonviability of the fetus;

(B) Acupuncture and biofeedback;

(C) Bone stimulators are not covered unless authorized by health maintenance organization (HMO) or POS;

(D) Care obtained outside the HMO or point-of-service (POS) service area which could have been anticipated prior to leaving the service area;

(E) Care received without charge, whether or not provided at a government facility;

(F) Cosmetic or reconstructive surgery, unless medically necessary to repair a functional disorder caused by disease, injury, or congenital defect;

(G) Custodial or domiciliary care;

(H) Experimental or investigational services, procedures, supplies or drugs as defined in the HMO or POS administrative guidelines;

(I) Growth hormone therapy unless authorized by the HMO or POS;

(J) Hearing aids:

1. HMO/POS—Limited to bilateral hearing aids every two (2) years;

2. Staff Model—Limited to bilateral hearing aids every three (3) years;

(K) Hypnosis;

(L) In addition to any other listed limitations, out-of-network services in a POS are subject to the three hundred dollar ($300) deductible and seventy/thirty percent (70%/30%) coinsurance (premium), sixty/forty percent (60%/40%) coinsurance (standard);

(M) Injuries and illness resulting out of course of employment and covered by Worker's Compensation, occupational disease law or similar law including, including all charges to be covered in any associated settlement agreement;

(N) Laetrile;

(O) Liability to provide services limited to the maximum capability of the HMO or POS in the event of major disaster, epidemic, war, riot, or other circumstances beyond the control of the HMO or POS;

(P) No coverage will be provided to the following procedures:

1. Reversal of voluntary sterilization;
2. *In vitro* fertilization;
3. Gamete intrafallopian transfer (GIFT); and
4. Zygote intrafallopian transfer (ZIFT);

(Q) Non-growth related replacement of prosthetics;

(R) Orthoptics;

(S) Out-of-network services without the proper referrals in an HMO (including staff model) are not covered services;

(T) Over-the-counter medications, except insulin;

(U) Personal comfort items;

(V) Physical examinations or immunizations requested by a third party;

(W) Physical fitness equipment;

(X) Private duty nursing unless authorized by the HMO or POS;

(Y) Services not deemed to be medically necessary;

(Z) Services not provided by an HMO contracted physician or provider unless prior approval received from the HMO;

(AA) Services not specifically included as benefits are not covered;

(BB) Services provided by family or household members;

(CC) Skilled nursing services are limited to one hundred (100) days annually (staff model), one hundred and twenty (120) days annually (HMO/POS);

(DD) Smoking cessation patches and gum;

(EE) Storage of whole blood, blood plasma, and blood products;

(FF) Transsexual surgery;

(GG) Travel and transportation expenses except those specifically listed under the covered benefits;

(HH) Treatment of military service-connected injury and illness;

(II) Treatment for obesity unless deemed medically necessary, including surgery, food supplements, behavior modification programs, and diet planning services;

(JJ) Treatment for temporal mandibular joint (TMJ) dysfunction; and

(KK) Trimming of nails, corns or calluses except for persons being treated for diabetes or peripheral vascular disease.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired August 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.070 Coordination of Benefits. This rule established the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;

3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;

4. A prepayment group plan which provides medical, vision, dental or health service;

5. Government plans, including Medicare;

6. Auto insurance when permitted by the laws of the state of jurisdiction; and

7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provided organization (PPO) type plans;

2. Types of plans for students; or

3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one (1) of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one (1) year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and

2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C), so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B)—

1. This plan contains a provision coordinating benefits with other plans; and

2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and

2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier;

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2. A. and B., if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first eighteen (18) months. Medicare is primary after the first eighteen (18) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one (1) of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsection (3)(C) and (D) shall not apply to the plan and this policy will pay as excess coverage.

*AUTHORITY section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.075 Review and Appeals Procedure. This rule established the policy of the board of trustees in regard to review and appeals procedure under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS) or preferred provider organization (PPO) health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(A) Appeals to the Board of Trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from

the member's health care plan, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
P.O. Box 104355
Jefferson City, MO 65110

(B) The Board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, make proposed Findings of Fact and Conclusions of Law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan contractor.

3. All parties shall be notified, in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. They may cross examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the Board shall carry the burden of proof.

6. The independent hearing officer shall propose Findings of Fact and Conclusions of Law, along with its recommendation, to the Board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The Board may, but is not required, to review the transcript of the hearing. It will review the summary of evidence, the proposed Findings of Fact and Conclusions of Law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the Board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the Board of Trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the Board, shall have the right of appeal as stated in subparagraph (5)(C) herein.

4. In reviewing these appeals, the Board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP.

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP Board for a decision.

B. Credible Evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of Plans Due to Dependent Change of Address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the Board of Trustees within 30 calendar days of the beginning of the new plan year. The MCHCP will respond within 30 calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.080 Miscellaneous Provisions. This rule established the policy of the board of trustees in regard to miscellaneous provisions for participants in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: It is imperative that this rule be rescinded immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule is rescinded to reflect changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rescission is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995,

effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RULE

22 CSR 10-2.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This rule must be in place by January 1, 2001, in accordance with the award of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2001, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency rule is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 12, 2000, becomes effective January 1, 2001, and expires on June 29, 2001.*

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Preferred provider organization (PPO) plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's opinion, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan and claims administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least 30 days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than 30 days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the 90-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than 30 days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 100—Division of Credit Unions
Chapter 2—State-Chartered Credit Unions

PROPOSED AMENDMENT

4 CSR 100-2.185 Investments in Fixed Assets. The director is amending section (1).

PURPOSE: This amendment is to exclude electronic data processing equipment from the definition of fixed assets.

(1) No credit union may invest more than five percent (5%) of total assets in fixed assets **(land and buildings)** without the prior approval of the director of the Missouri Division of Credit Unions. *[Fixed assets will include land, buildings and electronic data processing equipment.]*

*AUTHORITY: sections 370.075 and **370.100,** RSMo [1986] **2000**. Original rule filed Aug. 13, 1980, effective Jan. 30, 1981. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Division of Credit Unions, John P. Smith, Director, P.O. Box 1607, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register.** No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 100—Division of Credit Unions
Chapter 2—State-Chartered Credit Unions

PROPOSED AMENDMENT

4 CSR 100-2.220 External *[Borrowing]* **Deposits**. The director is deleting section (2) and amending section (3).

PURPOSE: The amendment eliminates deposits by credit unions in other credit unions from the definition of borrowing and increases the threshold for reporting to the Division of Credit Unions.

[(2) All deposits into any credit union by nonmembers which are also nonnatural persons shall be considered borrowing by the receiving credit union and subject to the limitations of section 370.290, RSMo.]

[(3)] **(2)** Any credit union which receives *[funds as described in sections (1) and (2)]* **deposits from nonmember nonnatural persons** must *[file a written report with]* **notify** the director of credit unions**, in writing,** within ten (10) days of *[its acceptance of those funds. This report must include a brief description of the uses of those funds by the receiving credit union, the date(s) received, the dollar amount(s) involved and the terms and conditions under which the funds were accepted.]* **the balance of all such deposits exceeding five percent (5%) of total shares and deposits.**

*AUTHORITY: section 370.100, RSMo [1986] **2000**. Emergency rule filed May 11, 1984, effective May 21, 1984, expired Sept. 18, 1984. Original rule filed May 11, 1984, effective Aug. 11, 1984. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Division of Credit Unions, John P. Smith, Director, P.O. Box 1607, Jefferson City, MO 65102. To be considered, comments must be

*received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 200—State Board of Nursing
Chapter 4—General Rules

PROPOSED AMENDMENT

4 CSR 200-4.010 Fees. The board is proposing to amend subsections (1)(A) through (1)(H) and (1)(J), delete subsection (1)(K) and renumber the remaining sections accordingly.

PURPOSE: Pursuant to 335.036.2., RSMo 1994, "The board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter." This amendment is necessary to cover operating costs. We have experienced a dramatic shortfall of 1.9 million dollars in the nursing fund. This shortfall has necessitated that we secure a loan until we can make up the shortfall by increasing revenue to cover our operating expenses. This amendment increases fees in order to cover operating expenses. Even though operating costs have increased each year, fees have not been increased to cover operating expenses. The fee to renew a RN or LPN license has not been increased since 1993. The fee for a license by endorsement has not been increased since 1986. The fee for a license by examination has not been increased since 1983. The annual accreditation fee has not been increased since 1993. The lapsed license fee has not been increased since 1981. The duplicate license fee, endorsement to another state and application fee for advanced practice nurse eligibility have never been increased.
The board is also proposing to delete subsection (1)(K) pursuant to Section 610.026, which states fees for copying records shall not exceed the actual cost of document search and duplication.

(1) The following fees are established by the State Board of Nursing:

(A) Examination Fee-Registered Professional Nurse (RN)	*[$ 20.00;]* **$ 45.00**
1. Reexamination Fee-RN	*[$ 15.00;]* **$ 40.00**
(B) Examination Fee Licensed Practical Nurse (LPN)	*[$ 11.00;]* **$ 41.00**
1. Reexamination Fee-LPN	*[$ 10.00;]* **$ 40.00**
(C) Endorsement Fee-RN	*[$ 30.00;]* **$ 55.00**
(D) Endorsement Fee-LPN	*[$ 26.00;]* **$ 51.00**
(E) Lapsed License Fee (in addition to renewal fee for each year of lapse)	*[$ 30.00;]* **$ 50.00**
(F) School Annual Registration Fee	*[$ 50.00;]* **$100.00**
(G) Verification Fee	*[$ 5.00;]* **$ 30.00**
(H) License Renewal Duplicate Fee	*[$ 5.00;]* **$15.00**
(I) Computer Print-Out of Licensees—not more than	$ 25.00
(J) Biennial Renewal Fee—	
1. RN	*[$ 60.00;]* **$ 100.00**
2. LPN	*[$ 52.00;]* **$ 92.00**

3. License renewal for a professional nurse shall be biennial; occurring on odd numbered years and the license shall expire on April 30 of each odd-numbered year beginning with the 1997–1999 renewal period. License renewal for a practical nurse shall be biennial; occurring on even-numbered years and the license shall expire on May 31 of each even-numbered year beginning with the 1998-2000 renewal period. Renewal shall be for a twenty-four (24)-month period except in instances when renewal for a greater or lesser number of months is caused by acts or policies of the Missouri State Board of Nursing. Renewal applications shall be mailed every even-numbered year by the Missouri State Board of Nursing to all LPNs currently licensed and every odd-numbered year to all RNs currently licensed;

4. A renewal fee of *[sixty dollars ($60)]* **one-hundred dollars ($100)** every other year for an RN effective with the 2001–2003 renewal period and *[fifty-two dollars ($52)]* **ninety-two dollars ($92.00)** every other year for an LPN effective *[with the 2000-2002 renewal period]* **January 1, 2001** shall be accepted by the Missouri State Board of Nursing only if accompanied by an appropriately completed renewal application; and

5. All fees established for licensure or licensure renewal of nurses incorporate an educational surcharge in the amount of one dollar ($1) per year for practical nurses and five dollars ($5) per year for professional nurses. These funds are deposited in the professional and practical nursing student loan and nurse repayment fund;

[(K) Photostatic Copy Fee (per page)	*$ 0.25;]*
[(L)] **(K)** Review and Challenge Fees—	
1. LPN	$100.00*[;]*
and	
2. RN	$100.00*[;]*
[(M)] **(L)** Uncollectible Fee (Charged for any uncollectible check or other uncollectible financial instrument submitted to the Missouri State Board of Nursing.)	$ 25.00*[;]*
[(N)] **(M)** Fee for Late Education Agenda Items	$ 30.00*[;]*
[(O)] **(N)** Application Fee for Proposals to Establish New Programs of Nursing	$500.00*[;]*
and	
[(P)] **(O)** Application Fee for Advanced Practice Nurse Eligibility	*[$ 75.00;]* **$150.00**

*AUTHORITY: sections 335.036 and 335.046, RSMo [1999] **2000**. Emergency rule filed Aug. 13, 1981, effective Aug. 23, 1981, expired Dec. 11, 1981. Original rule filed Aug. 13, 1981, effective Nov. 12, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 12, 2000. Emergency amendment filed Dec. 15, 2000, effective Jan. 1, 2001, expires June 29, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment is estimated to cost private entities an increase of approximately $3,078,285 during the first year of implementation of the rule, $1,092,935 for the second year of implementation of the rule and each biennially even numbered year thereafter for the life of rule; and $2,966,335 for the third year of implementation of the rule and each biennially odd numbered year thereafter for the life of rule. It is anticipated that this total increase will recur for the life, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee. A detailed fiscal note, which estimates the cost of compliance with this rule, has been filed with the Secretary of State.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed amendment with the Missouri State Board of Nursing, Calvina Thomas, Executive Director, PO Box 656, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COSTS

I. RULE NUMBER

Title 4 – Department of Economic Development

Division 200 – Missouri State Board of Nursing

Chapter 4 – General Rules

Proposed Amendment: 4 CSR 200-4.010 Fees

Prepared October 24, 2000 by the Missouri State Board of Nursing of the Department of Economic Development.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by types of the business entities which would likely be affected.	Annual estimated cost of compliance for the life of the rule:
1,858	RN graduates seeking a license in Missouri by exam (increase of $25)	$46,450
469	Repeat RN exam applicants seeking a license in Missouri (increase of $25)	$11,725
861	LPNs graduates seeking a license in Missouri by exam (increase of $30)	$25,830
186	Repeat LPN exam applicants seeking a license in Missouri (increase of $30)	$5,580
1,180	RNs licensed in another state seeking a license in Missouri (increase of $25)	$29,500
295	LPNs licensed in another state seeking a license in Missouri (increase of $25)	$7,375
300	Nurses with a lapsed nursing license seeking renewal (increase of $20)	$6,000
91	School Annual Registration Fee (increase of $50)	$4,550
4,478	Missouri Nurses seeking a license in another state –	$111,950

	(will phase out after first year of implementation of the rule) (increase of $25)	
1,104	Missouri nurses seeking a duplicate license (increase of $10)	$11,040
68,438	Currently Licensed RNs seeking licensure renewal (biennially each odd numbered year) (increase of $40)	$2,737,520
685	Non-Current RNs seeking licensure renewal (increase of $40)	$27,400
21,603	Currently Licensed LPNs seeking licensure renewal (biennially each even numbered year) (increase of $40)	$864,120
481	Non-Current LPNs seeking licensure renewal (increase of $40)	$19,240
455	Missouri nurses seeking APN recognition (increase of $75)	$34,125
	***Total estimated increase for the first year of implementation of the rule**	**$3,078,285**
	****Total estimated increase for the second year of implementation of the rule and each biennially even numbered year thereafter for the life of rule**	**$1,092,935**
	*****Total estimated increase for the third year of implementation of the rule and each biennially odd numbered year thereafter for the life of rule**	**$2,966,335**

III. WORKSHEET

In fiscal year 1999-2000, 1,956 graduates applied for a Missouri RN license by examination. This is a 5% decrease in the numbers that applied a year ago. With the 5% decrease, the number of projected applicants is 1,858. The increase for this service is $20 to $45. 1,858 times the $25 difference is $46,450 annually for the life of the rule. $5.00 of each $45 fee is for the nursing student loan fund administered through the Missouri Department of Health.

In fiscal year 1999-2000, 494 graduates applied for a repeat Missouri RN license by examination. With the decrease, we are projecting that 469 will apply this year. The increase for this service is $15 to $40. 469 times the $25 difference is $11,725 annually for the life of the rule.

In fiscal year 1999-2000, 1,196 graduates applied for a Missouri LPN license by examination. This is an 18% decrease in the numbers that applied a year ago. With an 18% decrease, the number of projected applicants is 861. The increase for this service is $11 to $41. 861 times the $30 difference is $25,830 annually for the life of the rule. $1 of each $41 fee is for the nursing student loan fund administered through the Missouri Department of Health.

In fiscal year 1999-2000, 221 graduates applied for a repeat Missouri LPN license by examination. With the decrease, we are projecting that 186 repeat LPN exam applicants will apply. The increase for this service is $10 to $40. 186 times the $30 difference is $5,580 annually for the life of the rule.

In fiscal year 1999-2000, 1,456 RNs applied for a license by endorsement. This is a 19% decrease in the number that applied a year ago. With the 19% decrease, the number of applicants is projected at 1,180. The increase for this service is $30 to $55. 1,180 times the $25 difference is $29,500 annually for the life of the rule. $5 of each $55 fee is for the nursing student loan fund administered through the Missouri Department of Health.

In fiscal year 1999-2000, 374 LPNs applied for a license by endorsement. This is a 21% decrease in the number that applied a year ago. With the 21% decrease, the number of applicants is projected at 295. The increase for this service is $26 to $51. 295 times the $25 difference is $7,375 annually for the life of the rule. $1 of each $51 fee is for the nursing student loan fund administered through the Missouri Department of Health.

In fiscal year 1999-2000, 300 nurses with a lapsed license sought licensure renewal. The increase of this service is $30.00 to $50.00. 300 times the $20 difference is $6,000 annually for the life of the rule.

There are currently 91 accredited/approved nursing programs. The increase in the school annual registration fee is from $50 to $100. 91 times the $50 difference is $4,550 annually for the life of the rule.

In fiscal year 1999-2000, 4,478 endorsements to other states were completed. The increase for this service is $5.00 to $30. 4,478 times the $25 increase is $111,950. This number is expected to decrease to 0 in the next fiscal year due to the implementation of the NurSys licensure system at which time the National Council of State Boards of Nursing will verify the licensure of nurses.

In fiscal year 1999-2000, 1,104 duplicate licenses were issued. The increase for this service is $5.00 to $15.00. 1,104 times the $10 increase is $11,040 annually for the life of the rule.

There are currently 75,207 active RNs in the State of Missouri. We are projecting a 9% decrease in the number of licensees. With a 9% decrease, the number of projected RN renewals is 68,438. The increase in the biennial renewal fee is from $60 to $100. 68,438 times the $40 difference is $2,737,520 biennially for the life of the rule. In addition, 685 of the non-current RNs renewed their license during the 1998-1999 fiscal year. 685 times the $40 difference is $27,400. $10 of

each $100 fee is for the nursing student loan fund administered through the Missouri Department of Health.

There are currently 21,603 active LPNs in the State of Missouri. The increase in the biennial renewal fee is from $52 to $92. 21,603 times the $40 difference is $864,120 biennially for the life of the rule. In addition, 481 of the non-current LPNs will renew their license during the 1998-1999 fiscal year. 481 times the $40 difference is $19,240. $2 of each $92 fee is for the nursing student loan fund administered through the Missouri Department of Health.

In fiscal year 1999-2000, 455 nurses applied for advanced practice nurse recognition. The increase in the application fee for advanced practice nurse eligibility is from $75 to $150. 455 times the $75 difference is $34,125 annually for the life of the rule.

IV. ASSUMPTIONS

The number of applicants utilized in this fiscal note is based on figures from fiscal year 1998-1999 and fiscal year 1999-2000. The board is not projecting any growth in licensees or applicants due to the current nursing shortage. However, if the number of applicants/licensees increases, the estimated private entity cost will increase by the number of applicants/licensees.

The proposed increases were determined by conducting a comprehensive analysis of the cost to the Board of Nursing for each service. The Missouri State Board of Nursing operates on fees collected by licensees and applicants.

The following represents the last time the board increased the various fees.

1981	Lapsed license fee increase from $25 to $50
1984	RN and LPN fee increase for a license in Missouri from another state
1984	RN and LPN examination fee increase
1991	Renewal fee increase
1991	Collect the amount charged for the nursing student loan fund ($5 per year for RNs and $1 per year for LPNs)

*First year estimates include RN examination fees, RN repeat examination fees, LPN examination fees, LPN repeat examination fees, RN endorsement fees, LPN endorsement fees, lapsed license fees, annual school registration fees, endorsement to another state fees, duplicate license fees, RN renewal fees, non-current RN renewal fees, non-current LPN renewal fees, and APN recognition fees. These fees are expected during the first year of implementation of the rule.

**Second year estimates include RN examination fees, RN repeat examination fees, LPN examination fees, LPN repeat examination fees, RN endorsement fees, LPN endorsement fees, lapsed license fees, annual school registration fees, duplicate license fees, LPN renewal fees, non-current RN renewal fees, non-current LPN renewal fees, and APN recognition fees. These estimates are expected to recur biennially in even numbered years for the life of the rule.

***Third year estimates include RN examination fees, RN repeat examination fees, LPN examination fees, LPN repeat examination fees, RN endorsement fees, LPN endorsement fees, lapsed license fees, annual school registration fees, duplicate license fees, RN renewal fees, non-current RN renewal fees, non-current LPN renewal fees, and APN recognition fees. These estimates are expected to recur biennially in odd numbered years for the life of the rule.

It is anticipated that this total increase will recur for the life, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards

PROPOSED AMENDMENT

4 CSR 240-40.020 Incident, Annual and Safety-Related Condition Reporting Requirements. The commission is amending sections (1) and (12).

PURPOSE: This proposed amendment modifies the scope of this rule to be consistent with 4 CSR 240-40.030 for gathering lines and amends the rule to conform to an amendment of 49 CFR part 191.

(1) Scope. (191.1)

(B) This rule does not apply to *[onshore]* gathering of gas **on private property** outside of—

1. An area within the limits of any incorporated or unincorporated city, town or village; or

2. Any designated residential or commercial area such as a subdivision, business or shopping center or community development.

(12) Reporting Safety-Related Conditions. (191.23)

(B) A report is not required for any safety-related condition that—

1. Exists on a master meter system or a customer-owned service line;

2. Is an incident or results in an incident before the deadline for filing the safety-related condition report;

3. Exists on a pipeline (other than an LNG facility) that is more than two hundred twenty (220) yards **(200 meters)** from any building intended for human occupancy or outdoor place of assembly, except that reports are required for conditions within the right-of-way of an active railroad, paved road, street or highway; or

4. Is corrected by repair or replacement in accordance with applicable safety standards before the deadline for filing the safety-related condition report, except that reports are required for conditions under paragraph (12)(A)1. other than localized corrosion pitting on an effectively coated and cathodically protected pipeline.

AUTHORITY: sections 386.250, [and] 386.310, [RSMo Supp. 1999] and 393.140, RSMo [1994] 2000. Original rule filed Feb. 5, 1970, effective Feb. 26, 1970. Amended: Filed Dec. 19, 1975, effective Dec. 29, 1975. Amended: Filed Feb. 8, 1985, effective Aug. 11, 1985. Rescinded and readopted: Filed May 17, 1989, effective Dec. 15, 1989. Amended: Filed Oct. 7, 1994, effective May 28, 1995. Amended: Filed April 9, 1998, effective Nov. 30, 1998. Amended: Filed Dec. 14, 2000.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file comments in support of or in opposition to this proposed amendment with the Missouri Public Service Commission, Dale Hardy Roberts, Secretary, P.O. Box 360, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. Comments should refer to Case No. GX-2001-91 and be filed with an original and eight (8) copies. No public hearing is scheduled.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards

PROPOSED AMENDMENT

4 CSR 240-40.030 Safety Standards—Transportation of Gas by Pipeline. The Commission is amending 4 CSR 240-40.030 sections (1)–(14), Appendix A, Appendix B and Appendix E.

PURPOSE: This amendment proposes to amend the rule to conform to amendments of 49 CFR part 192, to clarify the rule, and to make editorial changes.

(1) General.

(B) Definitions. (192.3) As used in this rule—

1. Abandoned means permanently removed from service;

[1.] **2.** Administrator means the Administrator of the Research and Special Programs Administration of the United States Department of Transportation or any person to whom authority in the matter concerned has been delegated by the Secretary of the United States Department of Transportation;

[2.] **3.** Building means any structure *[which]* **that** is regularly or periodically occupied by people;

[3.] **4.** Commission means the Missouri Public Service Commission, and designated commission personnel means the Pipeline Safety Program Manager at the address contained in 4 CSR 240-40.020(5) for required correspondence;

[4.] **5.** Distribution line means a pipeline other than a gathering or transmission line*[;*

5. Feeder], **and feeder** line means a distribution line that has a maximum allowable operating pressure **(MAOP)** greater than *[one hundred pounds per square inch gauge (100 psig), but]* **100 psi (689 kPa) gauge that** produces hoop stresses less than twenty percent (20%) **of** specified minimum yield strength (SMYS);

6. Follow-up inspection means an inspection performed after a repair procedure has been completed in order to determine the effectiveness of the repair and to *[insure]* **ensure** that all hazardous leaks in the area are corrected;

7. Fuel line means the customer-owned gas piping downstream from the outlet of the customer meter or operator-owned pipeline, whichever is farther downstream;

8. Gas means natural gas, flammable gas, manufactured gas or gas which is toxic or corrosive;

9. Gathering line means a pipeline that transports gas from a current production facility to a transmission line or main;

10. High-pressure distribution system means a distribution system in which the gas pressure in the main is higher than an equivalent to fourteen inches (14") water column;

11. Hoop stress means the stress in a pipe wall acting circumferentially in a plane perpendicular to the longitudinal axis of the pipe produced by the pressure in the pipe;

12. Listed specification means a specification listed in subsection I. of Appendix B;

13. Low pressure distribution system means a distribution system in which the gas pressure in the main is less than or equal to an equivalent of fourteen inches (14") water column;

14. Main means a distribution line that serves as a common source of supply for more than one (1) service line;

15. Maximum actual operating pressure means the maximum pressure that occurs during normal operations over a period of one (1) year;

16. Maximum allowable operating pressure (MAOP) means the maximum pressure at which a pipeline or segment of a pipeline may be operated under this rule;

17. Municipality means a city, village or town;

18. Operator means a person who engages in the transportation of gas, and person means any individual, firm, joint venture, partnership, corporation, association, county, state, municipality, political subdivision, cooperative association or joint stock association, and including any trustee, receiver, assignee or personal representative of them;

19. Petroleum gas means propane, propylene, butane (normal butane or *[isobultanes]* **isobutanes**), and butylene (including isomers), or mixtures composed predominately of these gases, having a vapor pressure not exceeding *[1434 kPa (208 psig) at 38°C (100°F)]* **208 psi (1434 kPa) gauge at 100°F (38°C)**;

20. Pipe means any pipe or tubing used in the transportation of gas, including pipe-type holders;

21. Pipeline means all parts of those physical facilities through which gas moves in transportation, including pipe, valves and other appurtenances attached to pipe, compressor units, metering stations, regulator stations, delivery stations, holders and fabricated assemblies;

22. Pipeline facility means new and existing pipeline, rights-of-way and any equipment, facility or building used in the transportation of gas or in the treatment of gas during the course of transportation;

23. Reading means the highest sustained reading when testing in a bar hole or opening without induced ventilation;

24. Service line means a distribution line that transports gas from a common source of supply to a) a customer meter or the connection to a customer's piping, whichever is farther downstream, or b) the connection to a customer's piping if there is no customer meter. A customer meter is the meter that measures the transfer of gas from an operator to a consumer;

25. SMYS means specified minimum yield strength is—

A. For steel pipe manufactured in accordance with a listed specification, the yield strength specified as a minimum in that specification; or

B. For steel pipe manufactured in accordance with an unknown or unlisted specification, the yield strength determined in accordance with paragraph (3)(D)2. (192.107[b]);

26. Sustained reading means the reading taken on a combustible gas indicator unit after adequately venting the test hole or opening;

27. Transmission line means a pipeline, other than a gathering line, that—

A. Transports gas from a gathering line or storage facility to a distribution center, storage facility, or large volume customer that is not downstream from a distribution center (A large volume customer may receive similar volumes of gas as a distribution center, and includes factories, power plants, and institutional users of gas.);

B. Operates a hoop stress of twenty percent (20%) or more of SMYS; or

C. Transports gas within a storage field;

28. Transportation of gas means the gathering, transmission or distribution of gas by pipeline or the storage of gas in Missouri;

29. Tunnel means a subsurface passageway large enough for a man to enter;

30. Vault or manhole means a subsurface structure that a man can enter; and

31. Yard line means an underground fuel line that transports gas from the service line to the customer's building. If multiple buildings are being served, building shall mean the building nearest to the connection to the service line. For purposes of this definition, if aboveground fuel line piping at the meter location is located within five feet (5') of a building being served by that meter, it shall be considered to the customer's building and no yard line exists. At meter locations where aboveground fuel line piping is located greater than five feet (5') from the building(s) being served, the underground fuel line from the meter to the entrance into the nearest building served by that meter shall be considered the yard line and any other lines are not considered yard lines.

(C) Class Locations. (192.5)

1. This subsection classifies pipeline locations for the purpose of this rule. The following criteria apply to classifications under this section:

A. A "class location unit" is an area that extends two hundred twenty (220) yards **(200 meters)** on either side of the centerline of any continuous one (1)-mile **(1.6 kilometers)** length of pipeline; and

B. Each separate dwelling unit in a multiple dwelling unit building is counted as a separate building intended for human occupancy.

2. Except as provided in paragraph (1)(C)3., pipeline locations are classified as follows:

A. A Class 1 location is any class location unit that has ten (10) or fewer buildings intended for human occupancy;

B. A Class 2 location is any class location unit that has more than ten (10) or but fewer than forty-six (46) buildings intended for human occupancy;

C. A Class 3 location is—

(I) Any class location unit that has forty-six (46) or more buildings intended for human occupancy; or

(II) An area where the pipeline lies within one hundred (100) yards **(91 meters)** of either a building or a small, well-defined outside area (*[for instance,]* **such as** a playground, recreation area, outdoor theater or other place of public assembly) that is occupied by twenty (20) or more persons on at least five (5) days a week for ten (10) weeks in any twelve (12)-month period (The days and weeks need not be consecutive); and

D. A Class 4 location is any class location unit where buildings with four (4) or more stories aboveground are prevalent.

3. The length of Class locations 2, 3, and 4 may be adjusted as follows:

A. A Class 4 location ends two hundred twenty (220) yards **(200 meters)** from the nearest building with four (4) or more stories aboveground; and

B. When a cluster of buildings intended for human occupancy requires a Class 2 or 3 location, the class location ends two hundred twenty (220) yards **(200 meters)** from the nearest building in the cluster.

(K) Customer Notification Required by Section 192.16 of 49 CFR part 192. (192.16)

1. This subsection applies to each operator of a service line who does not maintain the customer's buried piping up to entry of the first building downstream, or, if the customer's buried piping does not enter a building, up to the principal gas utilization equipment or the first fence (or wall) that surrounds that equipment. For the purpose of this subsection, "customer's buried piping" does not include branch lines that serve yard lanterns, pool heaters, or other types of secondary equipment. Also, "maintain" means monitor for corrosion according to subsection (9)(I) if the customer's buried piping is metallic, survey for leaks according to subsection (13)(M), and if an unsafe condition is found, take action according to paragraph (12)(S)3.

2. Each operator shall notify each customer once in writing of the following information:

A. The operator does not maintain the customer's buried piping;

B. If the customer's buried piping is not maintained, it may be subject to the potential hazards of corrosion and leakage;

C. Buried gas piping should be—

(I) Periodically inspected for leaks;

(II) Periodically inspected for corrosion if the piping is metallic; and

(III) Repaired if any unsafe condition is discovered;

D. When excavating near buried gas piping, the piping should be located in advance, and the excavation done by hand; and

E. The operator (if applicable), *[plumbers]* **plumbing contractors**, and heating contractors can assist in locating, inspecting, and repairing the customer's buried piping.

3. Each operator shall notify each customer not later than August 14, 1996, or ninety (90) days after the customer first receives gas at a particular location, whichever is later. However, operators of master meter systems may continuously post a general notice in a prominent location frequented by customers.

4. Each operator must make the following records available for inspection by designated commission personnel:

A. A copy of the notice currently in use; and

B. Evidence that notices have been sent to customers within the previous three (3) years.

(2) Materials.

(C) Steel Pipe. (192.55)

1. New steel pipe is qualified for use under this rule if—

A. It was manufactured in accordance with a listed specification;

B. It meets the requirements of—

(I) Subsection II of Appendix B to this rule; or

(II) If it was manufactured before November 12, 1970, either subsection II or III of Appendix B to this rule; or

C. It is used in accordance with paragraph (2)(C)3. or 4.

2. Used steel pipe is qualified for use under this rule if—

A. It was manufactured in accordance with a listed specification and it meets the requirements of paragraph II-C of Appendix B to this rule;

B. It meets the requirements of—

(I) Subsection II of Appendix B to this rule; or

(II) If it was manufactured before November 12, 1970, either subsection II or III of Appendix B to this rule;

C. It has been used in an existing line of the same or higher pressure and meets the requirements of paragraph II-C of Appendix B to this rule; or

D. It is used in accordance with paragraph (2)(C)3.

3. New or used steel pipe may be used at a pressure resulting in a hoop stress of less than six thousand (6,000) pounds per square inch (psi) **(41 MPa)** where no close coiling or close bending is to be done, if visual examination indicates that the pipe is in good condition and that it is free of split seams and other defects that would cause leakage. If it is to be welded, steel pipe that has not been manufactured to a listed specification must also pass the weldability tests prescribed in paragraph II-B of Appendix B to this rule.

4. Steel pipe that has not been previously used may be used as replacement pipe in a segment of pipeline if it has been manufactured prior to November 12, 1970, in accordance with the same specification as the pipe used in constructing that segment of pipeline.

5. New steel pipe that has been cold expanded must comply with the mandatory provisions of API Specification 5L.

(3) Pipe Design.

(C) Design Formula for Steel Pipe. (192.105)

1. The design pressure for steel pipe is determined in accordance with the following formula:

$$P = (2\ St/D) \times F \times E \times T$$

where—

P = Design pressure in pounds per square inch **(kPa)** gauge;

S = Yield strength in pounds per square inch **(kPa)** determined in accordance with subsection (3)(D); (192.107)

D = Nominal outside diameter of the pipe in inches **(millimeters)**;

t = Nominal wall thickness of the pipe in inches **(millimeters)**. If this is unknown, it is determined in accordance with subsection (3)(E) (192.109). Additional wall thickness required for concurrent external loads in accordance with subsection (3)(B) (192.103) may not be included in computing design pressure;

F = Design factor determined in accordance with subsection (3)(F) (192.111);

E = Longitudinal joint factor determined in accordance with subsection (3)(G) (192.113); and

T = Temperature derating factor determined in accordance with subsection (3)(H) (192.115).

2. If steel pipe that has been subjected to cold expansion to meet the SMYS is subsequently heated, other than by welding or stress relieving as a part of welding, the design pressure is limited to seventy-five percent (75%) of the pressure determined under paragraph (3)(C)1. if the temperature of the pipe exceeds *[nine hundred degrees Fahrenheit (900°F) (four hundred eighty-two degrees Celsius (482°C))]* **900°F (482°C)** at any time or is held above *[six hundred degrees Fahrenheit (600°F) (three hundred and sixteen degrees Celsius (316°C))]* **600°F (316°C)** for more than one (1) hour.

(D) Yield Strength (S) for Steel Pipe. (192.107)

1. For pipe that is manufactured in accordance with a specification listed in subsection I of Appendix B, the yield strength to be used in the design formula in subsection (3)(C) (192.105) is the SMYS stated in the listed specification, if that value is known.

2. For pipe that is manufactured in accordance with a specification not listed in subsection I of Appendix B or whose specification or tensile properties are unknown, the yield strength to be used in the design formula in subsection (3)(C) (192.105) is one (1) of the following:

A. If the pipe is tensile tested in accordance with paragraph II-D of Appendix B, the lower of the following:

(I) Eighty percent (80%) of the average yield strength determined by the tensile tests; or

(II) The lowest yield strength determined by the tensile tests; or

B. If the pipe is not tensile tested as provided in subparagraph (3)(D)2.A., twenty-four thousand (24,000) psi **(165 MPa)**.

(E) Nominal Wall Thickness (t) for Steel Pipe. (192.109)

1. If the nominal wall thickness for steel pipe is not known, it is determined by measuring the thickness of each piece of pipe at quarter points on one end.

2. However, if the pipe is of uniform grade, size, and thickness and there are more than ten (10) lengths, only ten percent (10%) of the individual lengths, but not less than ten (10) lengths, need to be measured. The thickness of the lengths that are not measured must be verified by applying a gauge set to the minimum thickness found by the measurement. The nominal wall thickness to be used in the design formula in subsection (3)(C) (192.105) is the next wall thickness found in commercial specifications that is below the average of all the measurements taken. However, the nominal wall thickness used may not be more than one and fourteen hundredths (1.14) times the smallest measurement taken on pipe less than twenty inches (20") **(508 millimeters)** in outside diameter, nor more than one and eleven hundredths (1.11) times the smallest measurement taken on pipe twenty inches (20") **(508 millimeters)** or more in outside diameter.

(G) Longitudinal Joint Factor (E) for Steel Pipe. (192.113) The longitudinal joint factor to be used in the design formula in subsection (3)(C) (192.105) is determined in accordance with the following table:

Specifications	Pipe Class	Longitudinal Joint Factor (E)
ASTM A 53	Seamless	1.00
	Electric resistance welded	1.00
	Furnace butt welded	0.60
ASTM A 106	Seamless	1.00
ASTM A 333/A 333M	Seamless	1.00
	Electric resistance welded	1.00
ASTM A 381	Double submerged arc welded	1.00
ASTM A 671	Electric fusion welded	1.00
ASTM A 672	Electric fusion welded	1.00
ASTM A 691	Electric fusion welded	1.00
API 5L	Seamless	1.00
	Electric resistance welded	1.00
	Electric flash welded	1.00
	Submerged arc welded	1.00
	Furnace butt welded	0.60
Other	Pipe over 4 inches **(102 millimeters)**	0.80
Other	Pipe 4 inches **(102 millimeters)** or less	0.60

If the type of longitudinal joint cannot be determined, the joint factor to be used must not exceed that designated for Other.

(H) Temperature Derating Factor (T) for Steel Pipe. (192.115) The temperature derating factor to be used in the design formula in subsection (3)(C) (192.105) is determined as follows:

Gas Temperature in Degrees Fahrenheit *(Celsius)*	Temperature Derating Factor (T)
250°**F (121°C)** or less	1.000
300°**F (149°C)**	0.967
350°**F (177°C)**	0.933
400°**F (204°C)**	0.900
450°**F (232°C)**	0.867

For intermediate gas temperatures, the derating factor is determined by interpolation.

(I) Design of Plastic Pipe. (192.121) Subject to the limitations of subsection (3)(J)(192.123), the design pressure for plastic pipe is determined in accordance with either of the following formulas:

$$P = 2\,S\,\frac{t}{(D-t)} \times 0.32$$

$$P = \frac{2\,S}{(SDR-1)} \times 0.32$$

where

P = Design pressure, **psi (kPa)** gauge*[, kPa (psig)]*;

S = For thermoplastic pipe**,** the long-term hydrostatic strength determined in accordance with the listed specification at a temperature equal to *[23°C (73°F), 38°C (100°F), 49°C (120°F) or 60°C (140°F), kPa (psi)]* **73°F (23°C), 100°F (38°C), 120°F (49°C) or 140°F (60°C), psi (kPa)**;

t = Specified wall thickness, *[mm (in)]* **in (mm)**;

D = Specified outside diameter, *[mm (in)]* **in (mm)**; and

SDR = Standard dimension ratio, the ratio of the average specified outside diameter to the minimum specified wall thickness, corresponding to a value from a common numbering system that was derived from the American National Standards Institute preferred number series 10.

(J) Design Limitations for Plastic Pipe. (192.123)

1. The design pressure may not exceed a gauge pressure of *[six hundred eighty-nine (689) kPa (100 psig)]* **100 psi (689 kPa) gauge** for plastic pipe used in—

A. Distribution systems; or

B. Classes 3 and 4 locations.

2. Plastic pipe may not be used where operating temperatures of the pipe will be*[—]***:**

A. Below *[–29°C (–20°F)]* **–20°F (–29°C)**, or *[–40°C (–40°F)]* **–40°F (–40°C)** if all pipe and pipeline components whose operating temperature will be below *[–29°C (–20°F)]* **–20°F (–29°C)** have a temperature rating by the manufacturer consistent with that operating temperature; or

B. Above the following applicable temperatures for thermoplastic pipe, the temperature at which the long-term hydrostatic strength used in the design formula under subsection (3)(I) (192.121) is determined. However, if the pipe was manufactured before May 18, 1978, and its long-term hydrostatic strength was determined at *[23°C (73°F)]* **73°F (23°C)**, it may be used at temperatures up to *[38°C (100°F)]* **100°F (38°C)**.

3. The wall thickness for thermoplastic pipe may not be less than *[1.57 millimeters (0.062 in)]* **0.062 inches (1.57 millimeters)**.

(K) Design of Copper Pipe for Repairs. (192.125)

1. Copper pipe used in mains must have a minimum wall thickness of 0.065 inches **(1.65 millimeters)** and must be hard drawn.

2. Copper pipe used in service lines must have a minimum wall thickness not less than that indicated in the following table:

Standard size (inch) *(millimeter)*	Nominal O.D. (inch) *(millimeters)*	Wall thickness (inch) *(millimeter)* Nominal	Tolerance
1/2 **(13)**	.625 **(16)**	.040 **(1.06)**	.0035 **(.0889)**
5/8 **(16)**	.750 **(19)**	.042 **(1.07)**	.0035 **(.0889)**
3/4 **(19)**	.875 **(22)**	.045 **(1.14)**	.004 **(.102)**
1 **(25)**	1.125 **(29)**	.050 **(1.27)**	.004 **(.102)**
1 1/4 **(32)**	1.375 **(35)**	.055 **(1.40)**	.0045 **(.1143)**
1 1/2 **(38)**	1.625 **(41)**	.060 **(1.52)**	.0045 **(.1143)**

3. Copper pipe used in mains and service lines may not be used at pressures in excess of *[one hundred (100) psig]* **100 psi (689 kPa) gauge**.

4. Copper pipe that does not have an internal corrosion resistant lining may not be used to carry gas that has an average hydrogen sulfide content of more than *[0.3 grains per one hundred (100) standard cubic feet]* **0.3 grains/100 ft^3 (6.9/m^3) under standard conditions. Standard conditions refers to 60°F and 14.7 psia (38°C and one atmosphere)** of gas.

(4) Design of Pipeline Components.

(D) Valves. *[(145)]* **(192.145)**

1. Except for cast iron and plastic valves, each valve must meet the minimum requirements, or the equivalent, of API 6D. A valve may not be used under operating conditions that exceed the applicable pressure-temperature ratings contained in those requirements.

2. Each cast iron and plastic valve must comply with the following:

A. The valve must have a maximum service pressure rating for temperatures that equal or exceed the maximum service temperature;

B. The valve must be tested as part of the manufacturing, as follows:

(I) With the valve in the fully open position, the shell must be tested with no leakage to a pressure at least one and one-half *[(1 1/2)]* **1.5** times the maximum service rating;

(II) After the shell test, the seat must be tested to a pressure not less than one and one-half *[(1 1/2)]* **1.5** times the maximum service pressure rating. Except for swing check valves, test pressure during the seat test must be applied successively on each

side of the closed valve with the opposite side open. No visible leakage is permitted; and

(III) After the last pressure test is completed, the valve must be operated through its full travel to demonstrate freedom from interference.

3. Each valve must be able to meet the anticipated operating conditions.

4. No valve having shell components made of ductile iron may be used at pressures exceeding eighty percent (80%) of the pressure ratings for comparable steel valves at their listed temperature. However, a valve having shell components made of ductile iron may be used at pressures up to eighty percent (80%) of the pressure ratings for comparable steel valves at their listed temperature, if—

A. The temperature-adjusted service pressure does not exceed *[one thousand (1000) psig]* **1,000 psi (7 MPa) gauge**; and

B. Welding is not used on any ductile iron component in the fabrication of the valve shells or their assembly.

C. No valve having pressure containing parts made of ductile iron may be used in the gas pipe components of compressor stations.

(G) Tapping. (192.151)

1. Each mechanical fitting used to make a hot tap must be designed for at least the operating pressure of the pipeline.

2. Where a ductile iron pipe is tapped, the extent of full-thread engagement and the need for the use of outside-sealing service connections, tapping saddles or other fixtures must be determined by service conditions.

3. Where a threaded tap is made in cast iron or ductile iron pipe, the diameter of the tapped hole may not be more than twenty-five percent (25%) of the nominal diameter of the pipe unless the pipe is reinforced, except that—

A. Existing taps may be used for replacement service, if they are free of cracks and have good threads; and

B. A one and one-fourth inch (1 1/4") **(32 millimeters)** tap may be made in a four-inch (4") **(102 millimeters)** cast iron or ductile iron pipe**,** without reinforcement.

4. However, in areas where climate, soil, and service conditions may create unusual external stresses on cast iron pipe, unreinforced taps may be used only on six-inch (6") **(152 millimeters)** or larger pipe.

(H) Components Fabricated by Welding. (192.153)

1. Except for branch connections and assemblies of standard pipe and fittings joined by circumferential welds, the design pressure of each component fabricated by welding, whose strength cannot be determined, must be established in accordance with paragraph UG-101 of section VIII*[,]*-Division I, of the *ASME Boiler and Pressure Vessel Code*.

2. Each prefabricated unit that uses plate and longitudinal seams must be designated, constructed and tested in accordance with section I, section VIII-Division 1, or section VIII-Division 2 of the *ASME Boiler and Pressure Vessel Code*, except for the following:

A. Regularly manufactured butt-welding fittings;

B. Pipe that has been produced and tested under a specification listed in Appendix B to this rule;

C. Partial assemblies such as split rings or collars; and

D. Prefabricated units that the manufacturer certifies have been tested to at least twice the maximum pressure to which they will be subjected under the anticipated operating conditions.

3. Orange-peel bull plugs and orange-peel swages may not be used on pipelines that are to operate at a hoop stress of twenty percent (20%) or more of the SMYS of the pipe.

4. Except for flat closures designed in accordance with section VIII of the *ASME Boiler and Pressure Code*, flat closures and fish tails may not be used on pipe that either operates at *[one hundred (100) psig]* **100 psi (689 kPa) gauge** or more, or is more than three inches (3") **(76 millimeters)** nominal diameter.

(M) Compressor Stations—Design and Construction. (192.163)

1. Location of compressor building. Except for a compressor building on a platform located in inland navigable waters, each main compressor building of a compressor station must be located on property under the control of the operator. It must be far enough away from adjacent property, not under control of the operator, to minimize the possibility of fire being communicated to the compressor building from structures on adjacent property. There must be enough open space around the main compressor building to allow the free movement of firefighting equipment.

2. Building construction. Each building on a compressor station site must be made of noncombustible materials if it contains either—

A. Pipe more than two inches (2") **(51 millimeters)** in diameter that is carrying gas under pressure; or

B. Gas handling equipment other than gas utilization equipment used for domestic purposes.

3. Exits. Each operating floor of a main compressor building must have at least two (2) separated and unobstructed exits located so as to provide a convenient possibility of escape and an unobstructed passage to a place of safety. Each door latch on a exit must be of a type which can be readily opened from the inside without a key. Each swinging door located in an exterior wall must be mounted to swing outward.

4. Fenced areas. Each fence around a compressor station must have at least two (2) gates located so as to provide a convenient opportunity for escape to a place of safety or have other facilities affording a similarly convenient exit from the area. Each gate located within two hundred feet (200') **(61 meters)** of any compressor plant building must open outward and, when occupied, must be openable from the inside without a key.

5. Electrical facilities. Electrical equipment and wiring installed in compressor stations must conform to the *National Electrical Code*, ANSI/NFPA 70, so far as that code is applicable.

(O) Compressor Stations—Emergency Shutdown. (192.167)

1. Except for unattended field compressor stations of one thousand (1,000) horsepower **(746 kilowatts)** or less, each compressor station must have an emergency shutdown system that meets the following:

A. It must be able to block gas out of the station and blow down the station piping;

B. It must discharge gas from the blowdown piping at a location where the gas will not create a hazard;

C. It must provide means for the shutdown of gas compressing equipment, gas fires, and electrical facilities in the vicinity of gas headers and in the compressor building, except that—

(I) Electrical circuits that supply emergency lighting required to assist station personnel in evacuating the compressor building and the area in the vicinity of the gas headers must remain energized; and

(II) Electrical circuits needed to protect equipment from damage may remain energized; and

D. It must be operable from at least two (2) locations, each of which is—

(I) Outside the gas area of the station;

(II) Near the exit gates if the station is fenced or near emergency exits if not fenced; and

(III) Not more than five hundred feet (500') **(153 meters)** from the limits of the station.

2. If a compressor station supplies gas directly to a distribution system with no other adequate source of gas available, the emergency shutdown system must be designed so that it will not function at the wrong time and cause an unintended outage on the distribution system.

3. On a platform located in inland navigable waters, the emergency shutdown system must be designed and installed to actuate automatically by each of the following events:

A. In the case of an unattended compressor station—

(I) When the gas pressure equals the maximum allowable operating pressure plus fifteen percent (15%); or

(II) When an uncontrolled fire occurs on the platform; and

B. In the case of a compressor station in a building—

(I) When an uncontrolled fire occurs in the building; or

(II) When the concentration of gas in air reaches fifty percent (50%) or more of the lower explosive limit in a building which has a source of ignition. For the purpose of part (4)(O)3.B.(II), an electrical facility which conforms to Class 1, Group D of the *National Electrical Code* is not a source of ignition.

(S) Pipe-Type and Bottle-Type Holders. (192.175)

1. Each pipe-type and bottle-type holder must be designed so as to prevent the accumulation of liquids in the holder, in connecting pipe, or in auxiliary equipment, that might cause corrosion or interfere with the safe operation of the holder.

2. Each pipe-type or bottle-type holder must have a minimum clearance from other holders in accordance with the following formula:

$$C = (3D \times P \times F)/1000 \quad \textbf{(C = (D \times P \times F)/2298)}$$

where

C = Minimum clearance between pipe containers or bottles in inches **(millimeters)**;

D = Outside diameter of pipe containers or bottles in inches **(millimeters)**;

P = Maximum allowable operating pressure, */psig/* **psi (kPa) gauge**; and

F = Design factor as set forth in subsection (3)(F) (192.111).

(T) Additional Provisions for Bottle-Type Holders. (192.177)

1. Each bottle-type holder must be—

A. Located on a site entirely surrounded by fencing that prevents access by unauthorized persons and with minimum clearance from the fence as follows:

Maximum Allowable Operating Pressure	**Minimum Clearance** */(feet)/* **feet (meters)**
Less than 1000 psi*/g/* **(7 MPa) gauge**	25 **(7.6)**
1000 psi*/g/* **(7 MPa) gauge** or more	100 **(31)**

B. Designed using the design factors set forth in subsection (3)(F) (192.111); and

C. Buried with a minimum cover in accordance with subsection (7)(N)**.** (192.327)*/./*

2. Each bottle-type holder manufactured from steel that is not weldable under field conditions must comply with the following:

A. A bottle-type holder made from alloy steel must meet the chemical and tensile requirements for the various grades of steel in ASTM A 372/A 372M;

B. The actual yield-tensile ratio of the steel may not exceed 0.85;

C. Welding may not be performed on the holder after it has been heat-treated or stress-relieved, except that copper wires may be attached to the small diameter portion of the bottle end closure for cathodic protection if a localized Thermit welding process is used;

D. The holder must be given a mill hydrostatic test at a pressure that produces a hoop stress at least equal to eighty-five percent (85%) of the SMYS; and

E. The holder, connection pipe and components must be leak tested after installation as required by section (10).

(U) Transmission Line Valves. (192.179)

1. Each transmission line must have sectionalizing block valves spaced as follows, unless in a particular case the administrator finds that alternative spacing would provide an equivalent level of safety:

A. Each point on the pipeline in a Class 4 location must be within two and one-half (2 1/2) miles **(4 kilometers)** of a valve;

B. Each point on the pipeline in a Class 3 location must be within four (4) miles **(6.4 kilometers)** of a valve;

C. Each point on the pipeline in a Class 2 location must be within seven and one-half (7 1/2) miles **(12 kilometers)** of a valve; and

D. Each point on the pipeline in a Class 1 location must be within ten (10) miles **(16 kilometers)** of a valve.

2. Each sectionalizing block valve on a transmission line must comply with the following:

A. The valve and the operating device to open or close the valve must be readily accessible and protected from tampering and damage; and

B. The valve must be supported to prevent settling of the valve or movement of the pipe to which it is attached.

3. Each section of a transmission line between main line valves must have a blowdown valve with enough capacity to allow the transmission line to be blown down as rapidly as practicable. Each blowdown discharge must be located so the gas can be blown to the atmosphere without hazard and, if the transmission line is adjacent to an overhead electric line, so that the gas is directed away from the electrical conductors.

(W) Vaults—Structural Design Requirements. (192.183)

1. Each underground vault or pit for valves, pressure relieving, pressure limiting or pressure regulating stations must be able to meet the loads which may be imposed upon it and to protect installed equipment.

2. There must be enough working space so that all of the equipment required in the vault or pit can be properly installed, operated and maintained.

3. Each pipe entering, or */located/* within, a regulator vault or pit must be steel for sizes ten inches (10") **(254 millimeters)**, and less, except that control and gauge piping may be copper. Where pipe extends through the vault or pit structure, provision must be made to prevent the passage of gases or liquids through the opening and to avert strains in the pipe.

(Y) Vaults—Sealing, Venting and Ventilation. (192.187) Each underground vault or closed top pit containing either a pressure regulating or reducing station, or a pressure limiting or relieving station, must be sealed, vented or ventilated, as follows:

1. When the internal volume exceeds two hundred (200) cubic feet **(5.7 cubic meters)—**

A. The vault or pit must be ventilated with two (2) ducts, each having at least the ventilating effect of a pipe four inches (4") **(102 millimeters)** in diameter;

B. The ventilation must be enough to minimize the formation of combustible atmosphere in the vault or pit; and

C. The ducts must be high enough above grade to disperse any gas-air mixtures that might be discharged;

2. When the internal volume is more than seventy-five (75) cubic feet **(2.1 cubic meters)** but less than two hundred (200) cubic feet **(5.7 cubic meters)**—

A. If the vault or pit is sealed, each opening must have tight fitting cover without open holes through which an explosive mixture might be ignited, and there must be a means for testing the internal atmosphere before removing the cover;

B. If the vault or pit is vented, there must be a means of preventing external sources of ignition from reaching the vault atmosphere; or

C. If the vault or pit is ventilated, paragraph (4)(Y)1. or 3. applies; and

3. If a vault or pit covered by paragraph (4)(Y)2. is ventilated by openings in the covers or gratings and the ratio of the internal volume, in cubic feet, to the effective ventilating area of the cover or grating, in square feet, is less than twenty to one (20:1), no additional ventilation is required.

(DD) Control of the Pressure of Gas Delivered from Transmission Lines and High-*[p]***P**ressure Distribution Systems to Service Equipment. (192.197) If the maximum allowable operating pressure of the system exceeds fourteen inches (14") water column, one (1) of the following methods must be used to regulate and limit, to the maximum safe value, the pressure of gas delivered to the customer:

1. A service regulator with a suitable over-pressure protection device set to limit, to a maximum safe value, the pressure of the gas delivered to the customer and another regulator located upstream from the service regulator. The upstream regulator may not be set to maintain a pressure higher than sixty (60) psi*[g]* **(414 kPa) gauge**. A device must be installed between the upstream regulator and the service regulator to limit the pressure on the inlet of the service regulator to sixty (60) psi*[g]* **(414 kPa) gauge** or less in case the upstream regulator fails to function properly. This device may be either a relief valve or an automatic shutoff that shuts and remains closed until manually reset, if the pressure on the inlet of the service regulator exceeds the set pressure (sixty (60) psi*[g]* **(414 kPa) gauge** or less);

2. A service regulator and a monitoring regulator set to limit, to a maximum safe value, the pressure of the gas delivered to the customer. A device or method that indicates the failure of the service regulator must also be provided. The service regulator must be monitored at intervals not exceeding fifteen (15) months, but at least once each calendar year for detection of a failure;

3. A service regulator with a relief valve vented to the outside atmosphere, with the relief valve set to open so that the pressure of gas going to the customer does not exceed a maximum safe value. The relief valve may either be built into the service regulator or it may be a separate unit installed downstream from the service regulator. This combination may be used alone only in those cases where the inlet pressure on the service regulator does not exceed the manufacturer's safe working pressure rating of the service regulator, and may not be used where the inlet pressure on the service regulator exceeds sixty (60) psi*[g]* **(414 kPa) gauge**. For higher inlet pressure, the methods in paragraph (4)(DD)1. or 2. must be used; or

4. A service regulator and an automatic shutoff device that closes upon a rise in pressure downstream from the regulator and remains closed until manually reset.

(FF) Required Capacity of Pressure Relieving and Limiting Stations. (192.201)

1. Each pressure relief station or pressure limiting station or group of those stations installed to protect a pipeline must have enough capacity, and must be set to operate, to *[insure]* **ensure** the following:

A. In a low pressure distribution system, the pressure may not cause the unsafe operation of any connected and properly adjusted gas utilization equipment; and

B. In pipelines other than a low pressure distribution system—

(I) If the maximum allowable operating pressure is sixty (60) psi*[g]* **(414 kPa) gauge** or more, the pressure may not exceed the maximum allowable operating pressure plus ten percent (10%) or the pressure that produces a hoop stress of seventy-five percent (75%) of SMYS, whichever is lower;

(II) If the maximum allowable operating pressure is twelve (12) psi*[g]* **(83 kPa) gauge** or more, but less than sixty (60) psi*[g]* **(414 kPa) gauge**, the pressure may not exceed the maximum allowable operating pressure plus six (6) psi*[g]* **(41 kPa) gauge**; or

(III) If the maximum allowable operating pressure is less than twelve (12) psi*[g]* **(83 kPa) gauge**, the pressure may not exceed the maximum allowable operating pressure plus fifty percent (50%).

2. When more than one (1) pressure regulating or compressor station feeds into a pipeline, relief valves or other protective devices must be installed at each station to ensure that the complete failure of the largest capacity regulator or compressor, or any single run of lesser capacity regulators or compressors in that station, will not impose pressures on any part of the pipeline or distribution system in excess of those for which it was designed, or against which it was protected, whichever is lower.

3. Relief valves or other pressure limiting devices must be installed at or near each regulator station in a low-pressure distribution system, with a capacity to limit the maximum pressure in the main to a pressure that will not exceed the safe operating pressure for any connected and properly adjusted gas utilization equipment.

(GG) Instrument, Control and Sampling Pipe and Components. (192.203)

1. Applicability. This subsection applies to the design of instrument, control and sampling pipe and components. It does not apply to permanently closed systems, such as fluid-filled temperature-responsive devices.

2. Materials and design. All materials employed for pipe and components must be designed to meet the particular conditions of service and the following:

A. Each takeoff connection and attaching boss, fitting or adapter must be made of suitable material, be able to withstand the maximum service pressure and temperature of the pipe or equipment to which it is attached and be designed to satisfactorily withstand all stresses without failure by fatigue;

B. Except for takeoff lines that can be isolated from sources of pressure by other valving, a shutoff valve must be installed in each takeoff line as near as practicable to the point of takeoff. Blowdown valves must be installed where necessary;

C. Brass or copper material may not be used for metal temperatures greater than four hundred degrees Fahrenheit (400°F) **(204°C)**;

D. Pipe or components that may contain liquids must be protected by heating or other means from damage due to freezing;

E. Pipe or components in which liquids may accumulate must have drains or drips;

F. Pipe or components subject to clogging from solids or deposits must have suitable connections for cleaning;

G. The arrangement of pipe, components and supports must provide safety under anticipated operating stresses;

H. Each joint between sections of pipe, and between pipe and valves or fittings, must be made in a manner suitable for the anticipated pressure and temperature condition. Slip-type expansion joints may not be used. Expansion must be allowed for by providing flexibility within the system itself; and

I. Each control line must be protected from anticipated causes of damage and must be designed and installed to prevent damage to any one (1) control line from making both the regulator and the overpressure protective device inoperative.

(5) Welding of Steel in Pipelines.

(E) Limitations on Welders. (192.229)

1. No welder whose qualification is based on nondestructive testing may weld compressor station pipe and components.

2. No welder may weld with a particular welding process unless, within the preceding six (6) calendar months, s/he has welded with that process.

3. A welder qualified under paragraph (5)(D)1. (192.227[a])—

A. May not weld on pipe to be operated at a pressure that produces a hoop stress of twenty percent (20%) or more of SMYS

unless within the preceding six (6) calendar months the welder has had one (1) weld tested and found acceptable under section 3 or 6 of API Standard 1104, except that a welder qualified under an earlier edition previously listed in Appendix A to 49 CFR Part 192 may weld but may not requalify under that earlier edition; and

B. May not weld on pipe to be operated at a pressure that produces a hoop stress of less than twenty percent (20%) of SMYS unless the welder is tested in accordance with subparagraph (5)(E)3.A. or requalifies under subparagraph (5)(E)4.A. or B.

4. A welder qualified under paragraph (5)(D)2. (192.227[b]) may not weld unless—

A. Within the preceding fifteen (15) calendar months, but at least once each calendar year, the welder has requalified under paragraph (5)(D)2. (192.227[b]); or

B. Within the preceding seven and one-half (7 1/2) calendar months, but at least twice each calendar year, the welder has had—

(I) A production weld cut out, tested, and found acceptable in accordance with the qualifying test; or

(II) For welders who work only on service lines two inches (2") **(51 millimeters)** or smaller in diameter, two (2) sample welds tested and found acceptable in accordance with the test in subsection III. of Appendix C to this rule.

(I) Inspection and Test of Welds. (192.241)

1. Visual inspection of welding must be conducted to *[insure]* **ensure** that—

A. The welding is performed in accordance with the welding procedure; and

B. The weld is acceptable under paragraph (5)(I)3.

2. The welds on a pipeline to be operated at a pressure that produces a hoop stress of twenty percent (20%) or more of SMYS must be nondestructively tested in accordance with subsection (5)(J) (192.243), except that welds that are visually inspected and approved by a qualified welding inspector need not be nondestructively tested if—

A. The pipe has a nominal diameter of less than six inches (6") **(152 millimeters)**; or

B. The pipeline is to be operated at a pressure that produces a hoop stress of less than forty percent (40%) of SMYS and the welds are so limited in number that nondestructive testing is impractical.

3. The acceptability of a weld that is nondestructively tested or visually inspected is determined according to the standards in section 6 of API Standard 1104. However, if a girth weld is unacceptable under those standards for a reason other than a crack, and if the Appendix to API Standard 1104 applies to the weld, the acceptability of the weld may be further determined under that Appendix.

(6) Joining of Materials Other Than by Welding.

(G) Plastic Pipe—Qualifying Joining Procedures. (192.283)

1. Heat fusion, solvent cement and adhesive joints. Before any written procedure established under paragraph (6)(B)2. (192.273[b]) is used for making plastic pipe joints by a heat fusion, solvent cement or adhesive method, the procedure must be qualified by subjecting specimen joints made according to the procedure to the following tests:

A. The burst test requirements of—

(I) In the case of thermoplastic pipe, paragraph 6.6 (Sustained Pressure Test) or paragraph 6.7 (Minimum Hydrostatic Burst Pressure [Quick Burst]) of ASTM D2513;

(II) In the case of thermosetting plastic pipe, paragraph 8.5 (Minimum Hydrostatic Burst Pressure) or paragraph 8.9 (Sustained Static Pressure Tests) of ASTM D2517; or

(III) In the case of electrofusion fittings for polyethylene pipe and tubing, paragraph 9.1 (Minimum Hydraulic Burst Pressure **Test**), paragraph 9.2 (Sustained Pressure Test), paragraph 9.3 (Tensile Strength Test), or paragraph 9.4 (Joint Integrity Tests) of ASTM Designation F1055;

B. For procedures intended for lateral pipe connections, subject a specimen joint made from pipe sections joined at right angles according to the procedure to a force on the lateral pipe until failure occurs in the specimen. If failure initiates outside the joint area, the procedure qualifies for use; and

C. For procedures intended for nonlateral pipe connections, follow the tensile test requirements of ASTM D638, except that the test may be conducted at ambient temperature and humidity. If the specimen elongates no less than twenty-five percent (25%) or failure initiates outside the joint area, the procedure qualifies for use.

2. Mechanical joints. Before any written procedure established under paragraph (6)(B)2. (192.273[b]) is used for making mechanical plastic pipe joints that are designed to withstand tensile forces, the procedure must be qualified by subjecting five (5) specimen joints made according to the procedure to the following tensile test:

A. Use an apparatus for the test as specified in ASTM D638 (except for conditioning);

B. The specimen must be of such length that the distance between the grips of the apparatus and the end of the stiffener does not affect the joint strength;

C. The speed of testing is *[five millimeters (5 mm) (0.20")]* **0.20 inches (5.0 mm)** per minute, plus or minus twenty-five percent (25%);

D. Pipe specimens less than *[one hundred and two millimeters (102 mm) (4")]* **4 inches (102 mm)** in diameter are qualified if the pipe yields to an elongation of no less than twenty-five percent (25%) or failure initiates outside the joint area;

E. Pipe specimens *[one hundred and two millimeters (102 mm) (4")]* **4 inches (102 mm)** and larger in diameter shall be pulled until the pipe is subjected to a tensile stress equal to or greater than the maximum thermal stress that would be produced by a temperature change of *[fifty-five degrees Celsius (55°C) (100°F)]* **100°F (38°C)** or until the pipe is pulled from the fitting. If the pipe pulls from the fitting, the lowest value of the five (5) test results or the manufacturer's rating, whichever is lower must be used in the design calculations for stress;

F. Each specimen that fails at the grips must be retested using new pipe; and

G. Results obtained pertain only to the specific outside diameter and material of the pipe tested, except that testing of a heavier wall pipe may be used to qualify pipe of the same material but with a lesser wall thickness.

3. A copy of each written procedure being used for joining plastic pipe must be available to the persons making and inspecting joints.

4. Pipe or fittings manufactured before July 1, 1980 may be used in accordance with procedures that the manufacturer certifies will produce a joint as strong as the pipe.

(7) General Construction Requirements for Transmission Lines and Mains.

(E) Repair of Steel Pipe. (192.309)

1. Each imperfection or damage that impairs the serviceability of a length of steel pipe must be repaired or removed. If a repair is made by grinding, the remaining wall thickness must at least be equal to either—

A. The minimum thickness required by the tolerances in the specification to which the pipe was manufactured; or

B. The nominal wall thickness required for the design pressure of the pipeline.

2. Each of the following dents must be removed from steel pipe to be operated at a pressure that produces a hoop stress of twenty percent (20%) or more of SMYS**, unless the dent is**

repaired by a method that reliable engineering tests and analyses show can permanently restore the serviceability of the pipe:

A. A dent that contains a stress concentrator such as a scratch, gouge, groove or arc burn;

B. A dent that affects the longitudinal weld or circumferential weld; and

C. In pipe to be operated at a pressure that produces a hoop stress of forty percent (40%) or more of SMYS, a dent that has a depth of—

(I) More than one-quarter inch (1/4") **(6.4 millimeters)** in pipe twelve and three-quarters inches (12 3/4") **(324 millimeters)** or less in outer diameter; or

(II) More than two percent (2%) of the nominal pipe diameter in pipe over twelve and three-quarters inches (12 3/4") **(324 millimeters)** in outer diameter.

For the purpose of this subsection, a "dent" is a depression that produces a gross disturbance in the curvature of the pipe wall without reducing the pipe-wall thickness. The depth of a dent is measured as the gap between the lowest point of the dent and a prolongation of the original contour of the pipe.

3. Each arc burn on steel pipe to be operated at a pressure that produces a hoop stress of forty percent (40%) or more of SMYS must be repaired or removed. If a repair is made by grinding, the arc burn must be completely removed and the remaining wall thickness must be at least equal to either—

A. The minimum wall thickness required by the tolerances in the specification to which the pipe was manufactured; or

B. The nominal wall thickness required for the design pressure of the pipeline.

4. A gouge, groove, arc burn or dent may not be repaired by insert patching or by pounding out.

5. Each gouge, groove, arc burn or dent that is removed from a length of pipe must be removed by cutting out the damaged portion as a cylinder.

(G) Bends and Elbows. (192.313)

1. Each field bend in steel pipe, other than a wrinkle bend made in accordance with subsection (7)(H) (192.315), must comply with the following:

A. A bend must not impair the serviceability of the pipe;

B. Each bend must have a smooth contour and be free from buckling, cracks or any other mechanical damage; and

C. On pipe containing a longitudinal weld, the longitudinal weld must be as near as practicable to the neutral axis of the bend unless—

(I) The bend is made with an internal bending mandrel; or

(II) The pipe is twelve inches (12") **(305 millimeters)** or less in outside diameter or has a diameter-to-wall thickness ratio less than seventy (70).

2. Each circumferential weld of steel pipe which is located where the stress during bending causes a permanent deformation in the pipe must be nondestructively tested either before or after the bending process.

3. Wrought-steel welding elbows and transverse segments of these elbows may not be used for changes in direction on steel pipe that is two inches (2") **(51 millimeters)** or more in diameter unless the arc length, as measured along the crotch, is at least one inch (1") **(25 millimeters)**.

(H) Wrinkle Bends in Steel Pipe. (192.315)

1. A wrinkle bend may not be made on steel pipe to be operated at a pressure that produces a hoop stress of thirty percent (30%), or more, of SMYS.

2. Each wrinkle bend on steel pipe must comply with the following:

A. The bend must not have any sharp kinks;

B. When measured along the crotch of the bend, the wrinkles must be a distance of at least one (1) pipe diameter;

C. On pipe sixteen inches (16") **(406 millimeters)** or larger in diameter, the bend may not have a deflection of more than one and one-half degrees (1 1/2°) for each wrinkle; and

D. On pipe containing a longitudinal weld the longitudinal seam must be as near as practicable to the neutral axis of the bend.

(K) Installation of Plastic Pipe. (192.321)

1. Plastic pipe must be installed below ground level unless otherwise permitted by paragraph (7)(K)7.

2. Plastic pipe that is installed in a vault or any other below grade enclosure must be completely encased in gastight metal pipe and fittings that are adequately protected from corrosion.

3. Plastic pipe must be installed so as to minimize shear or tensile stresses.

4. Thermoplastic pipe that is not encased must have a minimum wall thickness of 0.090 inches (0.090") **(2.29 millimeters)**, except that pipe with an outside diameter of 0.875 inches (0.875") **(22.3 millimeters)** or less may have a minimum wall thickness of 0.062 inches (0.062") **(1.58 millimeters)**.

5. Plastic pipe that is not encased must have an electrically conductive wire or other means of locating the pipe while it is underground.

6. Plastic pipe that is being encased must be inserted into the casing pipe in a manner that will protect the plastic. The leading end of the plastic must be closed before insertion.

7. Uncased plastic pipe may be temporarily installed above ground level under the following conditions:

A. The operator must be able to demonstrate that the cumulative aboveground exposure of the pipe does not exceed the manufacturer's recommended maximum period of exposure or two (2) years, whichever is less;

B. The pipe either is located where damage by external forces is unlikely or is otherwise protected against such damage; and

C. The pipe adequately resists exposure to ultraviolet light and high and low temperatures.

(M) Underground Clearance. (192.325)

1. Each transmission line must be installed with at least twelve inches (12") **(305 millimeters)** of clearance from any other underground structure not associated with the transmission line. If this clearance cannot be attained, the transmission line must be protected from damage that might result from the proximity of the other structure.

2. Each main must be installed with enough clearance from any other underground structure to allow proper maintenance and to protect against damage that might result from proximity to other structures.

3. In addition to meeting the requirements of paragraph (7)(M)1. or 2., each plastic transmission line or main must be installed with sufficient clearance, or must be insulated, from any source of heat so as to prevent the heat from impairing the serviceability of the pipe.

4. Each pipe-type or bottle-type holder must be installed with a minimum clearance from any other holder as prescribed in paragraph (4)(S)2. (192.175[b])

(N) Cover. (192.327)

1. Except as provided in paragraphs (7)(N)3. and 5., each buried transmission line must be installed with a minimum cover as follows:

Location	Normal Soil (//inches) *(millimeters)*	Consolidated Rock *(millimeters)*
Class 1 locations	30 **(762)**	18 **(457)**
Class 2, 3, and 4 locations	36 **(914)**	24 **(610)**
Drainage ditches of public roads and railroad crossings	36 **(914)**	24 **(610)**

2. Except as provided in paragraphs (7)(N)3. and 4., each buried main must be installed with at least twenty-four inches (24") **(610 millimeters)** of cover.

3. Where an underground structure prevents the installation of a transmission line or main with the minimum cover, the transmission line or main may be installed with less cover if it is provided with additional protection to withstand anticipated external loads.

4. A main may be installed with less than twenty-four inches (24") **(610 millimeters)** of cover if the law of the state or municipality—

A. Establishes a minimum cover of less than twenty-four inches (24") **(610 millimeters)**;

B. Requires that mains be installed in a common trench with other utility lines; and

C. Provides adequately for prevention of damage to the pipe by external forces.

5. Except as provided in paragraph (7)(N)3. *[of this section]*, all pipe installed in a navigable river, stream or harbor must be installed with a minimum cover of forty-eight inches (48") **(1219 millimeters)** in soil or twenty-four inches (24") **(610 millimeters)** in consolidated rock between the top of the pipe and the natural bottom.

(8) Customer Meters, Service Regulators and Service Lines.

(C) Customer Meters and Regulators*[:]*—Location. (192.353)

1. Each meter and service regulator, whether inside or outside of a building, must be installed in a readily accessible location and be protected from corrosion, anticipated vehicular traffic and other damage. However, the upstream regulator in a series may be buried.

2. Each service regulator installed within a building must be located as near as practical to the point of service line entrance.

3. Each meter installed within a building must be located in a ventilated place and not less than three feet (3') **(914 millimeters)** from any source of ignition or any source of heat which might damage the meter.

4. Where feasible, the upstream regulator in a series must be located outside the building, unless it is located in a separate metering or regulating building.

(F) Customer Meter Installations—Operating Pressure. (192.359)

1. A meter may not be used at a pressure that is more than sixty-seven percent (67%) of the manufacturer's shell test pressure.

2. Each newly installed meter manufactured after November 12, 1970, must have been tested to a minimum of ten (10) psi*/g/* **(69 kPa) gauge**.

3. A rebuilt or repaired tinned steel case meter may not be used at a pressure that is more than fifty percent (50%) of the pressure used to test the meter after rebuilding or repairing.

(G) Service Lines—Installation. (192.361)

1. Depth. Each buried service line must be installed with at least twelve inches (12") **(305 millimeters)** of cover in private property and at least eighteen inches (18") **(457 millimeters)** of cover in streets and roads, except a plastic service line that is not inserted in a metallic casing must be installed with at least eighteen inches (18") **(457 millimeters)** of cover in all locations. However, where an underground structure prevents installation at those depths, the service line must be able to withstand any anticipated external load.

2. Support and backfill. Each service line must be properly supported on undisturbed or well-compacted soil, and material used for backfill must be free of materials that could damage the pipe or its coating.

3. Grading for drainage. Where condensate in the gas might cause interruption in the gas supply to the customer, the service line must be graded so as to drain into the main or into drips at the low points in the service line.

4. Protection against piping strain and external loading. Each service line must be installed so as to minimize anticipated piping strain and external loading.

5. Installation of service lines into buildings. Each underground service line installed below grade through the outer foundation wall of a building must—

A. In the case of a metal service line, be protected against corrosion;

B. In the case of a plastic service line, be protected from shearing action and backfill settlement; and

C. Be sealed at the foundation wall to prevent leakage into the building.

6. Installation of service lines under buildings. Where an underground service line is installed under a building—

A. It must be encased in a gastight conduit;

B. The conduit and the service line must extend, if the service line supplies the building it underlies, into a normally usable and accessible part of the building; and

C. The space between the conduit and the service line must be sealed to prevent gas leakage into the building and, if the conduit is sealed at both ends, a vent line from the annular space must extend to a point where gas would not be a hazard, and extend above grade, terminating in a rain and insect resistant fitting.

(L) Service Lines—Steel. (192.371) Each steel service line to be operated at less than one hundred (100) psi*/g/* **(689 kPa) gauge** must be constructed of pipe designed for a minimum of one hundred (100) psi*/g/* **(689 kPa) gauge**.

(O) Service Lines—Excess Flow Valve Performance Standards. (192.381)

1. Excess flow valves to be used on single residence service lines that operate continuously throughout the year at a pressure not less than ten (10) psi*/g/* **(69 kPa) gauge** must be manufactured and tested by the manufacturer according to an industry specification, or the manufacturer's written specification, to ensure that each valve will—

A. Function properly up to the maximum operating pressure at which the valve is rated;

B. Function properly at all temperatures reasonably expected in the operating environment of the service line;

C. At ten (10) psi*/g/* **(69 kPa) gauge**:

(I) Close at, or not more than fifty percent (50%) above, the rated closure flow rate specified by the manufacturer; and

(II) Upon closure, reduce gas flow—

(a) For an excess flow valve designed to allow pressure to equalize across the valve, to no more than five percent (5%) of the manufacturer's specified closure flow rate, up to a maximum of twenty (20) cubic feet per hour **(0.57 cubic meters per hour)**; or

(b) For an excess flow valve designed to prevent equalization of pressure across the valve, to no more than 0.4 cubic feet per hour **(0.01 cubic meters per hour)**; and

D. Not close when the pressure is less than the manufacturer's minimum specified operating pressure and the flow rate is below the manufacturer's minimum specified closure flow rate.

2. An excess flow valve must meet the applicable requirements of sections (2) and (4).

3. An operator must mark or otherwise identify the presence of an excess flow valve in the service line.

4. An operator shall locate an excess flow valve as near as practical to the fitting connecting the service line to its source of gas supply.

5. An operator should not install an excess flow valve on a service line where the operator has prior experience with contaminants in the gas stream, where these contaminants could be expected to cause the excess flow valve to malfunction or where the excess flow valve would interfere with necessary operation and

maintenance activities on the service line, such as blowing liquids from the service line.

(P) Excess Flow Valve Customer Notification. (192.383)

1. Definitions for subsection (8)(P).

A. Costs associated with installation means the costs directly connected with installing an excess flow valve, for example, costs of parts, labor, inventory and procurement. It does not include maintenance and replacement costs until such costs are incurred.

B. Replaced service line means a natural gas service line where the fitting that connects the service line to the main is replaced or the piping connected to this fitting is replaced.

C. Service line customer means the person who pays the gas bill, or where service has not yet been established, the person requesting service.

2. Which customers must receive notification. Notification is required on each newly installed service line or replaced service line that operates continuously throughout the year at a pressure not less than ten (10) psi (69 kPa) gauge and that serves a single residence. On these lines an operator of a natural gas distribution system must notify the service line customer once in writing.

3. What to put in the written notice.

A. An explanation for the customer that an excess flow valve (EFV) meeting the performance standards prescribed under subsection (8)(O) is available for the operator to install if the customer bears the costs associated with installation;

B. An explanation for the customer of the potential safety benefits that may be derived from installing an EFV. The explanation must include that an EFV is designed to shut off flow of natural gas automatically if the service line breaks; and

C. A description of installation, maintenance, and replacement costs. The notice must explain that if the customer requests the operator to install an EFV, the customer bears all costs associated with installation, and what those costs are. The notice must alert the customer that costs for maintaining and replacing an EFV may later be incurred, and what those costs will be, to the extent known.

4. When notification and installation must be made.

A. After February 3, 1999, an operator must notify each service line customer set forth in paragraph (8)(P)2.:

(I) On new service lines when the customer applies for service; and

(II) On replaced service lines when the operator determines the service line will be replaced.

B. If a service line customer requests installation, an operator must install the EFV at a mutually agreeable date.

5. What records are required.

A. An operator must make the following records available for inspection by designated commission personnel:

(I) A copy of the notice currently in use; and

(II) Evidence that notice has been sent to the service line customers set forth in paragraph (8)(P)2., within the previous three years.

B. (Reserved)

6. When notification is not required. The notification requirements do not apply if the operator can demonstrate—

A. That the operator will voluntarily install an excess flow valve or that the state or local jurisdiction requires installation;

B. That excess flow valves meeting the performance standards in subsection (8)(O) are not available to the operator;

C. That the operator has prior experience with contaminants in the gas stream that could interfere with the operation of an excess flow valve, cause loss of service to a residence, or interfere with necessary operation or maintenance activities, such as blowing liquids from the line; or

D. That an emergency or short time notice replacement situation made it impractical for the operator to notify a service line customer before replacing a service line. Examples of these situations would be where an operator has to replace a service line quickly because of—

(I) Third party excavation damage;

(II) Class 1 leaks as defined in the paragraph (14)(C)1.; or

(III) A short notice service line relocation request.

(9) Requirements for Corrosion Control.

(F) External Corrosion Control—Inspection of Buried Pipeline When Exposed. (192.459) Whenever an operator has knowledge that any portion of a buried metallic pipeline is exposed, an inspection of the exposed portion must be conducted. If the pipe is coated, the condition of the coating must be determined. If the pipe is bare or if the coating is deteriorated, the surface of the pipe must be examined for evidence of external corrosion. *[If the operator finds that there is active corrosion, that the surface of the pipe is pitted due to corrosion, or that corrosion has caused a leak, it shall investigate by records review and by excavation to determine the extent of the corrosion requiring remedial action.]* If external corrosion *[is found,]* **requiring** remedial action *[must be taken to the extent required by]* **under** subsections (9)(R) **through (9)(U)** (192.483 **through 192.489**) *[and the applicable paragraphs of subsections of (9)(S), (T) or (U). (192.485, 192.487, or 192.489)]* **is found, the operator shall investigate circumferentially and longitudinally beyond the exposed portion (by visual examination, indirect method, or both) to determine whether additional corrosion requiring remedial action exists in the vicinity of the exposed portion.**

(I) External Corrosion Control—Monitoring. (192.465)

1. Each pipeline that is under cathodic protection must be tested at least once each calendar year, but with intervals not exceeding fifteen (15) months, to determine whether the cathodic protection meets the requirements of subsection (9)(H). (192.463) However, if tests at those intervals are impractical for separately protected short sections of mains or transmission lines, not in excess of one hundred feet (100') **(30 meters)**, or separately protected service lines, these pipelines may be surveyed on a sampling basis. At least twenty percent (20%) of these protected structures, distributed over the entire system, must be surveyed each calendar year, with a different twenty percent (20%) checked each subsequent year, so that the entire system is tested in each five (5)-year period. Each short section of metallic pipe less than one hundred feet (100') **(30 meters)** in length installed and cathodically protected in accordance with paragraph (9)(R)2. (192.483[b]), each segment of pipe cathodically protected in accordance with paragraph (9)(R)3. (192.483[c]) and each electronically isolated metallic fitting not meeting the requirements of paragraph (9)(D)5. (192.455[f]) must be monitored at a minimum rate of ten percent (10%) each calendar year, with a different ten percent (10%) checked each subsequent year, so that the entire system is tested every ten (10) years.

2. Each cathodic protection rectifier or other impressed current power source must be inspected six (six) times each calendar year but with intervals not exceeding two and one-half (2 1/2) months to *[insure]* **ensure** that it is operating.

3. Each reverse current switch, each diode and each interference bond whose failure would jeopardize structure protection must be electrically checked for proper performance six (6) times each calendar year, but with intervals not exceeding two and one-half (2 1/2) months. Each other interference bond must be checked at least once each calendar year, but with intervals not exceeding fifteen (15) months.

4. Each operator shall take prompt remedial action to correct any deficiencies indicated by the monitoring required in para-

graphs (9)(I)1.–3. Corrective measures must be completed within six (6) months unless otherwise approved by designated commission personnel.

5. After the initial evaluation required by paragraph (9)(D)2. (192.455[c]) and paragraph (9)(E)2. (192.457[b]), each operator, at intervals not exceeding three (3) years, shall reevaluate its unprotected pipelines and cathodically protect them in accordance with this section in areas in which active corrosion is found, except that unprotected steel service lines must be replaced as required by subsection (15)(C). The operator shall determine the areas of active corrosion by electrical survey at intervals not exceeding three (3) years. Where electrical survey is impractical, the areas of active corrosion shall be determined by the study of corrosion and leak history records and by instrument leak detection survey at intervals not exceeding three (3) years. When the operator conducts electrical surveys, the operator must demonstrate that the surveys effectively identify areas of active corrosion.

(N) Internal Corrosion Control—General. (192.475)

1. Corrosive gas may not be transported by pipeline, unless the corrosive effect of the gas on the pipeline has been investigated and steps have been taken to minimize internal corrosion.

2. Whenever any pipe is removed from a pipeline for any reason, the internal surface must be inspected for evidence of corrosion. If internal corrosion is found—

A. The adjacent pipe must be investigated to determine the extent of internal corrosion;

B. Replacement must be made to the extent required by the applicable paragraphs of subsections (9)(S), (T) or (U) (192.485, 192.487 or 192.489); and

C. Steps must be taken to minimize the internal corrosion.

3. Gas containing more than 0.25 grain of hydrogen sulfide per one hundred (100) *[standard]* cubic feet **(5.8 milligrams/m^3) at standard conditions** (four (4) parts per million) may not be stored in pipe-type or bottle-type holders.

(S) Remedial Measures—Transmission Lines. (192.485)

1. General corrosion. Each segment of transmission line with general corrosion and with a remaining wall thickness less than that required for the maximum allowable operating pressure of the pipeline must be replaced or the operating pressure reduced commensurate with the strength of the pipe based on actual remaining wall thickness. However, *[if the area of general corrosion is small, the]* corroded pipe may be repaired **by a method that reliable engineering tests and analyses show can permanently restore the serviceability of the pipe**. Corrosion pitting so closely grouped as to affect the overall strength of the pipe is considered general corrosion for the purpose of this paragraph.

2. Localized corrosion pitting. Each segment of transmission line pipe with localized corrosion pitting to a degree where leakage might result must be replaced or repaired, or the operating pressure must be reduced commensurate with the strength of the pipe, based on the actual remaining wall thickness in the pits.

3. Under paragraphs (9)(S)1. and (9)(S)2., the strength of pipe based on actual remaining wall thickness may be determined by the procedure in ASME/ANSI B31G or the procedure in AGA Pipeline Research Committee Project PR 3-805 (with RSTRENG disk). Both procedures apply to corroded regions that do not penetrate the pipe wall, subject to the limitations prescribed in the procedures.

(T) Remedial Measures—Distribution Lines Other Than Cast Iron or Ductile Iron Lines. (192.487)

1. General corrosion. Except for cast iron or ductile iron pipe, each segment of generally corroded distribution line pipe with a remaining wall thickness less than that required for the maximum allowable operating pressure of the pipeline, or a remaining wall thickness less than thirty percent (30%) of the nominal wall thickness, must be replaced. However, *[if the area of general corrosion is small, the]* corroded pipe may be repaired **by a method that reliable engineering tests and analyses show can permanently restore the serviceability of the pipe**. Corrosion pitting so closely grouped as to affect the overall strength of the pipe is considered general corrosion for the purpose of this paragraph.

2. Localized corrosion pitting. Except for cast iron or ductile iron pipe, each segment of distribution line pipe with localized corrosion pitting to a degree where leakage might result must be replaced or repaired.

(V) Corrosion Control Records. (192.491)

1. Each operator shall maintain records or maps to show the location of cathodically protected piping, cathodic protection facilities, galvanic anodes, and neighboring structures bonded to the cathodic protection system. Records or maps showing a stated number of anodes, installed in a stated manner or spacing, need not show specific distances to each buried anode. Each operator shall develop and maintain maps showing, at a minimum: the location of cathodically protected mains (except for short sections less than one hundred feet (100') in length); feeder lines; and transmission lines; and all cathodic protection facilities such as rectifiers, test points (except for service riser locations that are not used each year), electrical isolating devices that separate protection zones and interference bonds.

2. Each record or map required by paragraph (9)(V)1. must be retained for as long as the pipeline remains in service.

3. Each operator shall maintain a record of each test, survey, inspection *[or]* **and** remedial action required by this section in sufficient detail to demonstrate the adequacy of corrosion control measures or that a corrosive condition does not exist. These records must be retained for at least five (5) years, except that records related to paragraphs (9)(I)1., (9)(I)4., (9)(I)5., and (9)(N)2. must be retained for as long as the pipeline remains in service.

(10) Test Requirements.

(C) Strength Test Requirements for Steel Pipeline to Operate at a Hoop Stress of Thirty Percent (30%) or More of SMYS. (192.505)

1. Except for service lines, each segment of a steel pipeline that is to operate at a hoop stress of thirty percent (30%) or more of SMYS must be strength tested in accordance with this subsection to substantiate the proposed maximum allowable operating pressure. In addition, in a Class 1 or Class 2 location, if there is a building intended for human occupancy within three hundred feet (300') **(91 meters)** of a pipeline, a hydrostatic test must be conducted to a test pressure of at least one hundred twenty-five percent (125%) of maximum operating pressure on that segment of the pipeline within three hundred feet (300') **(91 meters)** of such a building, but in no event may the test section be less than six hundred feet (600') **(183 meters)** feet unless the length of the newly installed or relocated pipe is less than six hundred feet (600') **(183 meters)**. However, if the buildings are evacuated while the hoop stress exceeds fifty percent (50%) of SMYS, air or inert gas may be used as the test medium.

2. In a Class 1 or Class 2 location, each compressor station, regulator station and measuring station must be tested to at least Class 3 location test requirements.

3. Except as provided in paragraph (10)(C)5., the strength test must be conducted by maintaining the pressure at or above the test pressure for at least eight (8) hours.

4. If a component other than pipe is the only item being replaced or added to a pipeline, a strength test after installation is not required, if the manufacturer of the component certifies that—

A. The component was tested to at least the pressure required for the pipeline to which it is being added; or

B. The component was manufactured under a quality control system that ensures that each item manufactured is at least equal in strength to a prototype and that the prototype was tested

to at least the pressure required for the pipeline to which it is being added.

5. For fabricated units and short sections of pipe, for which a post-installation test is impractical, a pre-installation strength test must be conducted by maintaining the pressure at or above the test pressure for at least four (4) hours.

(D) Test Requirements for Pipelines to Operate at a Hoop Stress Less Than Thirty Percent (30%) of SMYS and at or Above One Hundred (100) psi*/g/* **(689 kPa) gauge**. (192.507) Except for service lines and plastic pipelines, each segment of a pipeline that is to be operated at a hoop stress less than thirty percent (30%) of SMYS and at or above one hundred (100) psi*/g/* **(689 kPa) gauge** must be tested in accordance with subparagraph (12)(M)1.B. and the following:

1. The pipeline operator must use a test procedure that will ensure discovery of all potentially hazardous leaks in the segment being tested;

2. If, during the test, the segment is to be stressed to twenty percent (20%) or more of SMYS and natural gas, inert gas or air is the test medium—

A. A leak test must be made at a pressure between one hundred (100) psi*/g/* **(689 kPa) gauge** and the pressure required to produce a hoop stress of twenty percent (20%) of SMYS; or

B. The line must be walked to check for leaks while the hoop stress is held at approximately twenty percent (20%) of SMYS.

3. The pressure must be maintained at or above the test pressure for at least one (1) hour.

(E) Test Requirements for Pipelines to Operate Below One Hundred (100) psi*/g/* **(689 kPa) gauge**. (192.509) Except for service lines and plastic pipelines, each segment of a pipeline that is to be operated below one hundred (100) psi*/g/* **(689 kPa) gauge** must be tested in accordance with the following:

1. The test procedure used must ensure discovery of all potentially hazardous leaks in the segment being tested;

2. Each main that is to be operated at less than one (1) psi*/g/* **(6.9 kPa) gauge** must be tested to at least ten (10) psi*/g/* **(69 kPa) gauge**, each main to be operated at or above one (1) psi*/g/* **(6.9 kPa) gauge** through ninety (90) psi*/g/* **(621 kPa) gauge** must be tested to at least ninety (90) psi*/g/* **(621 kPa) gauge**, and each main that is to be operated between ninety (90) psi*/g/* **(621 kPa) gauge** and one hundred (100) psi*/g/* **(689 kPa) gauge** must be tested to at least one hundred (100) psi*/g/* **(689 kPa) gauge**.

(F) Test Requirements for Service Lines. (192.511)

1. Each segment of a service line (other than plastic) must be leak tested in accordance with this subsection before being placed in service. If feasible, the service line connection to the main must be included in the test; if not feasible, it must be given a leakage test at the operating pressure when placed in service.

2. Each segment of a service line (other than plastic) intended to be operated at a pressure of at least one (1) psi*/g/* **(6.9 kPa) gauge** but not more than forty (40) psi*/g/* **(276 kPa) gauge** must be given a leak test at a pressure of not less than fifty (50) psi*/g/* **(345 kPa) gauge**.

3. Each segment of a service line (other than plastic) intended to be operated at pressures of more than forty (40) psi*/g/* **(276 kPa) gauge** through ninety (90) psi*/g/* **(621 kPa) gauge** must be tested to at least ninety (90) psi*/g/* **(621 kPa) gauge**; if the service line is to be operated between ninety (90) psi*/g/* **(621 kPa) gauge** and one hundred (100) psi*/g/* **(689 kPa) gauge**, it must be tested to at least one hundred (100) psi*/g/* **(689 kPa) gauge**; and if the service line may be operated at 100 psi*/g/* **(689 kPa) gauge** or more, it must, at a minimum, be tested using the appropriate factor in subparagraph (12)(M)1.B. of this rule, except that each segment of the steel service line stressed to twenty percent (20%) or more of SMYS must be tested in accordance with subsection (10)(D) *[of this rule. (192.507)]*.

(G) Test Requirements for Plastic Pipelines. (192.513)

1. Each segment of a plastic pipeline must be tested in accordance with this subsection.

2. The test procedure must ensure discovery of all potentially hazardous leaks in the segment being tested.

3. The test pressure must be at least one hundred fifty percent (150%) of the maximum allowable operating pressure or fifty (50) psi*/g/* **(345 kPa) gauge**, whichever is greater. However, the maximum test pressure may not be more than three (3) times the pressure determined under subsection (3)(I), at a temperature not less than the pipe temperature during the test.

4. During the test, the temperature of thermoplastic material may not be more than *[38°C (100°F)]* **100°F (38°C)**, or the temperature at which the material's long-term hydrostatic strength has been determined under the listed specification, whichever is greater.

(H) Environmental Protection and Safety Requirements. (192.515)

1. In conducting tests under this section, each operator shall ensure that every reasonable precaution is taken to protect its employees and the general public during the testing. Whenever the hoop stress of the segment of the pipeline being tested will exceed fifty percent (50%) of SMYS, the operator shall take all practicable steps to keep persons not working on the testing operation outside of the testing area until the pressure is reduced to or below the proposed maximum allowable operating pressure.

2. The operator shall *[insure]* **ensure** that the test medium is disposed of in a manner that will minimize damage to the environment.

(11) Uprating.

(D) Uprating—Steel Pipelines to a Pressure That Will Produce a Hoop Stress Less Than Thirty Percent (30%) of SMYS—Plastic, Cast Iron and Ductile Iron Pipelines. (192.557)

1. Unless the requirements of this subsection have been met, no person may subject—

A. A segment of steel pipeline to an operating pressure that will produce a hoop stress less than thirty percent (30%) of SMYS and that is above the previously established maximum allowable operating pressure; or

B. A plastic, cast iron or ductile iron pipeline segment to an operating pressure that is above the previously established maximum allowable operating pressure.

2. Before increasing operating pressure above the previously established maximum allowable operating pressure, the operator shall—

A. Review the design, operating and maintenance history of the segment of pipeline;

B. Conduct a leak detection instrument survey (if it has been more than one (1) year since the last survey conducted with a leak detection instrument) and repair any leaks that are found, except that a leak determined not to be potentially hazardous need not be repaired, if it is monitored during the pressure increase and it does not become potentially hazardous;

C. Make any repairs, replacements or alterations in the segment of pipeline that are necessary for safe operation at the increased pressure;

D. Reinforce or anchor offsets, bends and dead ends in pipe joined by compression couplings or bell and spigot joints to prevent failure of the pipe joint, if the offset, bend or dead end is exposed in an excavation;

E. Isolate the segment of pipeline in which the pressure is to be increased from any adjacent segment that will continue to be operated at a lower pressure; and

F. If the pressure in mains or service lines, or both, is to be higher than the pressure delivered to the customer, install a service regulator on each service line and test each regulator to determine that it is functioning. Pressure may be increased as necessary

to test each regulator, after a regulator has been installed on each pipeline subject to the increased pressure.

3. After complying with paragraph(11)(D)2., the increase in maximum allowable operating pressure must be made in accordance with paragraph (11)(B)5. The pressure must be increased in increments that are equal to ten (10) psi*[g]* **(69 kPa) gauge** or twenty-five percent (25%) of the total pressure increase, whichever produces the fewer number of increments. Whenever the requirements of subparagraph (11)(D)2.F. apply, there must be at least two (2) approximately equal incremental increases.

4. If records for cast iron or ductile iron pipeline facilities are not complete enough to determine stresses produced by internal pressure, trench loading, rolling loads, beam stresses and other bending loads, in evaluating the level of safety of the pipeline when operating at the proposed increased pressure, the following procedures must be followed:

A. In estimating the stresses, if the original laying conditions cannot be ascertained, the operator shall assume that cast iron pipe was supported on blocks with tamped backfill and that ductile iron pipe was laid without blocks with tamped backfill;

B. Unless the actual maximum cover depth is known, the operator shall measure the actual cover in at least three (3) places where the cover is most likely to be greatest and shall use the greatest cover measured;

C. Unless the actual nominal wall thickness is known, the operator shall determine the wall thickness by cutting and measuring coupons from at least three (3) separate pipe lengths. The coupons must be cut from pipe lengths in areas where the cover depth is most likely to be the greatest. The average of all measurements taken must be increased by the allowance indicated in the following table:

	Allowance (inches) ***(millimeters)***		
	Cast iron pipe		
Pipe size (inches) ***(millimeters)***	**Pit cast pipe**	**Centrifugally cast pipe**	**Ductile iron pipe**
3 to 8 **(76 to 203)**	0.075 **(1.91)**	0.065 **(1.65)**	0.065**(1.65)**
10 to 12 **(254 to 305)**	0.08 **(2.03)**	0.07 **(1.78)**	0.07 **(1.78)**
14 to 24 **(356 to 610)**	0.08 **(2.03)**	0.08 **(2.03)**	0.075 **(1.91)**
30 to 42 **(762 to 1067)**	0.09 **(2.29)**	0.09 **(2.29)**	0.075 **(1.91)**
48 **(1219)**	0.09 **(2.29)**	0.09 **(2.29)**	0.08 **(2.03)**
54 to 60 **(1372 to 1524)**	0.09 **(2.29)**	—	—

D. For cast iron pipe, unless the pipe manufacturing process is known, the operator shall assume that the pipe is pit cast pipe with a bursting tensile strength of eleven thousand (11,000) psi **(76 MPa)** and a modulus of rupture of thirty-one thousand (31,000) psi **(214 MPa)**.

(12) Operations.

(D) *[Personnel]* Qualification **of Pipeline Personnel (Subpart N)**.

[1. No operator may permit an individual (operators themselves, employees of operators, independent contractors and subcontractors, and employees of these contractors) to perform on a pipeline system an operation, maintenance or emergency-response function regulated by this rule unless that individual has been trained and successfully completed a test designed to demonstrate possession of the knowledge and skills required under paragraph (12)(D)2. The test shall be written, hands-on, or oral, or any combination of these methods. For some functions, a test might consist of observing on-the-job performance supplemented by appropriate queries. An individual who does not meet these requirements may be permitted to perform such a function when directly supervised by someone who has properly met the requirements for qualifications.]

1. Scope. (192.801)

A. This subsection prescribes the minimum requirements for operator qualification of individuals performing covered tasks on a pipeline facility. This subsection applies to all individuals who perform covered tasks, regardless of whether they are employed by the operator, a contractor, a subcontractor, or any other entity performing covered tasks on behalf of the operator.

B. For the purpose of this subsection, a covered task is an activity, identified by the operator, that:

(I) Is performed on a pipeline facility;

(II) Is an operations, maintenance or emergency-response task;

(III) Is performed as a requirement of this rule; and

(IV) Affects the operation or integrity of the pipeline.

2. Definitions. (192.803)

A. Abnormal operating condition means a condition identified by the operator that may indicate a malfunction of a component or deviation from normal operations that may:

(I) Indicate a condition exceeding design limits;

(II) Result in a hazard(s) to persons, property, or the environment; or

(III) Require an emergency response.

B. Evaluation (or evaluate) means a process consisting of training and examination, established and documented by the operator, to determine an individual's ability to perform a covered task and to demonstrate that an individual possesses the knowledge and skills under paragraph (12)(D)4. After initial evaluation for paragraph (12)(D)4., subsequent evaluations for paragraph (12)(D)4. can consist of examination only. The examination portion of this process shall be conducted by one or more of the following:

(I) Written examination;

(II) Oral examination;

(III) Hands-on examination, which could involve observation supplemented by appropriate queries. Observations can be made during:

(a) Performance on the job;

(b) On the job training; or

(c) Simulations.

C. Qualified means that an individual has been evaluated and can:

(I) Perform assigned covered tasks; and

(II) Recognize and react to abnormal operating conditions.

3. Qualification program. (192.805) Each operator shall have and follow a written qualification program. The program shall include provisions to:

A. Identify covered tasks;

B. Ensure through evaluation that individuals performing covered tasks are qualified;

C. Allow individuals that are not qualified pursuant to this subsection to perform a covered task if directed and observed by an individual that is qualified;

D. Evaluate an individual if the operator has reason to believe that the individual's performance of a covered task contributed to an incident meeting the Missouri reporting requirements in 4 CSR 240-40.020(4)(A);

E. Evaluate an individual if the operator has reason to believe that the individual is no longer qualified to perform a covered task;

F. Communicate changes, including changes to rules and procedures, that affect covered tasks to individuals performing those covered tasks and their supervisors, and incorporate those changes in subsequent evaluations;

G. Identify the interval for each covered task at which evaluation of the individual's qualifications is needed, with a maximum interval of thirty-nine (39) months;

H. Evaluate an individual's possession of the knowledge and skills under paragraph (12)(D)4. at intervals not to exceed thirty-nine (39) months; and

I. Ensure that covered tasks are:

(I) Performed by qualified individuals; or

(II) Directed and observed by qualified individuals.

[2.] **4.** Personnel to whom this **sub**section applies must *[be trained]* **possess the knowledge and skills necessary** to —

A. *[Perform]* **Follow** the requirements of this rule that relate to *[their assigned functions]* **the covered tasks they perform**;

B. Carry out the procedures in the procedural manual for operations, maintenance and emergencies established under subsection (12)(C) (192.605) that relate to *[their assigned functions]* **the covered tasks they perform**;

C. Utilize instruments and equipment that relate to *[their assigned functions]* **the covered tasks they perform** in accordance with manufacturer's instructions;

D. Know the characteristics and hazards of the gas transported, including flammability range, *[and toxicity, olfactory]* **odorant characteristics** and corrosive properties;

E. Recognize potential ignition sources;

F. Recognize conditions that are likely to cause emergencies, including equipment or facility malfunctions or failure and gas leaks, predict potential consequences of these conditions and take appropriate corrective action;

G. Take steps necessary to control any accidental release of gas and to minimize the potential for fire *[,]* **or** explosion *[or toxicity]*; and

H. Know the proper use of firefighting procedures and equipment, fire suits and breathing apparatus by utilizing, where feasible, a simulated pipeline emergency condition.

[3. At intervals of not more than three (3) years, personnel to whom this section applies who are previously qualified under paragraph (12)(D)1. must attend training to refresh their knowledge and skills required under paragraph (12)(D)2. Except that individuals such as welders and persons who join plastic pipe who are requalified under other subsections of this rule are not required to attend the training required by subparagraph (12)(D)2.A.

4. Each operator shall keep personnel to whom this subsection applies informed of any changes to this rule and the procedural manual for operations, maintenance and emergencies that relate to their assigned functions, and incorporate those changes in training provided under this subsection.]

5. Each operator shall *[annually review with operating and maintenance personnel their performance in meeting the objectives of the training program at intervals not exceeding fifteen (15) months.]* **continue to meet the training and annual review requirements regarding the operator's emergency procedures in subparagraph (12)(J)2.B., in addition to the qualification program required in paragraph (12)(D)3.**

6. Each operator shall *[require and verify that]* **provide instruction to the** supervisors *[maintain a thorough knowledge of that portion of the procedures required by this subsection for which they are responsible to ensure compliance.]* **or designated persons who will determine when an evaluation is necessary under subparagraph (12)(D)3.E.**

7. Each operator shall select appropriately knowledgeable individuals to provide training and to perform evaluations. Where hands-on examinations and observations are used, the evaluator should possess the required knowledge to ascertain an individual's ability to perform covered tasks and react to abnormal operating conditions that might occur while performing those tasks.

[7] **8. Record keeping. (192.807)** Each operator shall maintain records that demonstrate *[that personnel have been qualified as required by paragraph (12)(D)1. and attended training as required by paragraph (12)(D)3. The records must be maintained during that individual's employment and for at least three (3) years thereafter.]* **compliance with this subsection.**

A. Qualification records shall include:

(I) Identification of the qualified individual(s);

(II) Identification of the covered tasks the individual is qualified to perform;

(III) Date(s) of current qualification; and

(IV) Qualification method(s).

B. Records supporting an individual's current qualification shall be maintained while the individual is performing the covered task. Records of prior qualification and records of individuals no longer performing covered tasks shall be retained for a period of five (5) years.

9. General. (192.809)

A. Subsection (12)(D) for personnel qualification was promulgated in 1989, effective December 15, 1989. Operators were required to meet the training and testing requirements within eighteen (18) months following the effective date, or June 15, 1991. At that time, there were no federal requirements for personnel qualification.

B. Subpart N to 49 CFR 192 (Subpart N) was adopted with federal regulations for qualification of pipeline personnel, effective October 26, 1999. Subsection (12)(D) is being amended in 2000 to incorporate much of Subpart N, including all requirements in Subpart N that are more stringent than the original subsection (12)(D). However, subsection (12)(D) as amended is different from and more stringent than Subpart N, primarily because training and testing is still required and work performance history review is not permitted as an evaluation method. Operators should continue to comply with the original subsection (12)(D) until the following deadlines, which are from Subpart N.

(I) Operators must have a written qualification program by April 27, 2001.

(II) Operators must complete the qualification of individuals performing covered tasks by October 28, 2002.

(I) Damage Prevention Program. (192.614)

1. Except for pipelines listed in *[paragraph (12)(I)5.]* **paragraphs (12)(I)6. and 7.**, each operator of a buried pipeline shall carry out in accordance with this subsection a written program to prevent damage to that pipeline by excavation activities. For the purpose of this subsection, excavation activities include excavation, blasting, boring, tunneling, backfilling, *[and]* the removal of aboveground structures by either explosive or mechanical means**,** and other *[earth moving]* **earthmoving** operations. Particular attention should be given to excavation activities in close proximity to cast iron mains with remedial actions taken as required by subsection (13)(Z). (192.755) *[An operator may perform any of the duties required by paragraph (12)(I)2. through participation in a public service program, such as a one-call system but such participation does not relieve the operator of responsibility for compliance with this subsection.]*

2. An operator may perform any of the duties required by paragraph (12)(I)3. through participation in a public service program, such as a one-call system, but such participation does not relieve the operator of responsibility for compliance with this subsection. However, an operator must perform the duties of subparagraph (12)(I)3.D. through participation in the qualified one-call system for Missouri. An operator's pipeline system must be covered by the qualified one-call system for Missouri.

[2.] **3.** The damage prevention program required by paragraph (12)(I)1. must, at a minimum—

A. Include the identity, on a current basis, of persons who normally engage in excavation activities in the area in which the

pipeline is located. A listing of persons involved in excavation activities shall be maintained and updated at least once each calendar year with intervals not exceeding fifteen (15) months. If an operator chooses to participate in an excavator education program of a one-call notification center, as provided for in subparagraphs *[(12)(I)2.B. and C.]* **(12)(I)3.B and C.**, then such updated listing shall be provided to the one-call notification center prior to December 1 of each calendar year. This list should at least include, but not be limited to, the following:

(I) Excavators, contractors, construction companies, engineering firms, etc.—Identification of these should at least include a search of the phone book yellow pages, checking with the area and/or state office of the Associated General Contractors and checking with the operating engineers local union hall(s);

(II) Telephone company;

(III) Electric utilities and co-ops;

(IV) Water and sewer utilities;

(V) City governments;

(VI) County governments;

(VII) Special road districts:

(VIII) Special water and sewer districts; and

(IX) Highway department district(s);

B. Provide for at least a semiannual general notification of the public in the vicinity of the pipeline. Provide for actual notification of the persons identified in subparagraph *[(12)(I)2.A.]* **(12)(I)3.A.**, at least once each calendar year at intervals not exceeding fifteen (15) months by registered or certified mail, or notification through participation in an excavator education program of a one-call notification center meeting the requirements of subparagraph *[(12)(I)2.C.]* **(12)(I)3.C.** Mailings to excavators shall include a copy of the applicable sections of Chapter 319, RSMo, or a summary of the provisions of Chapter 319, RSMo approved by designated commission personnel, concerning underground facility safety and damage prevention pertaining to excavators. The operator's public notifications and excavator notifications shall include information concerning the existence and purpose of the operator's damage prevention program, as well as information on how to learn the location of underground pipelines before excavation activities are begun;

C. In order to provide for an operator's compliance with the excavator notification requirements of subparagraph *[(12)(I)2.B.]* **(12)(I)3.B.**, a one-call system's excavator education program must:

(I) Maintain and update a comprehensive listing of excavators who use the one-call notification center and who are identified by the operators pursuant to the requirements of subparagraph *[(12)(I)2.A.]* **(12)(I)3.A.**;

(II) Provide for at least semi*[-]*annual educational mailings to the excavators named on the comprehensive listing maintained pursuant to *[(12)(I)2.C.(I)]* **part (12)(I)3.C.(I)**, by first class mail; and

(III) Provide for inclusion of the following in at least one (1) of the semiannual mailings required by part *[(12)(I)2.C.(II)]* **(12)(I)3.C.(II)**: Chapter 319, RSMo or a summary of the provisions of Chapter 319, RSMo approved by designated commission personnel, concerning underground facility safety and damage prevention which pertain to excavators; an explanation of the types of temporary markings normally used to identify the approximate location of underground facilities; and a description of the availability and proper use of the one-call system's notification center;

D. Provide a means of receiving and recording notification of planned excavation activities;

E. Include maintenance of records for subparagraphs *[(12)(I)2.B.–D.]* **(12)(I)3.B.–D.** as follows:

(I) Copies of the two (2) most recent annual notifications sent to excavators identified in **subparagraph** *[(12)(I)2.A.]* **(12)(I)3.A.**, or the four (4) most recent semiannual notifications sent in accordance with subparagraph *[(12)(I)2.C.]* **(12)(I)3.C.**, must be retained;

(II) Copies of notifications required in subparagraph *[(12)(I)2.D.]* **(12)(I)3.D.** shall be retained for at least two (2) years. At a minimum, these records should include the date and the time the request was received, the actions taken pursuant to the request, and the date the response actions were taken; and

(III) Copies of notification records required by Chapter 319, RSMo to be maintained by the notification center shall be available to the operator for at least five (5) years;

F. If the operator has buried pipelines in the area of excavation activity, provide for actual notification of persons who give notice of their intent to excavate of the type of temporary marking to be provided and how to identify the markings;

G. Provide for temporary marking of buried pipelines in the area of excavation activity before, as far as practical, the activity begins; and

H. Provide as follows for inspection of pipelines that an operator has reason to believe could be damaged by excavation activities:

(I) The inspection must be done as frequently as necessary during and after the activities to verify the integrity of the pipeline; and

(II) In the case of blasting, any inspection must include leakage surveys.

[3.] **4.** Each notification identified in subparagraph *[(12)(I)2.D.]* **(12)(I)3.D.** should be evaluated to determine the need for and the extent of inspections. The following factors should be considered in determining the need for and extent of those inspections:

A. The type and duration of the excavation activity involved;

B. The proximity to the operator's facilities;

C. The type of excavating equipment involved;

D. The importance of the operator's facilities;

E. The type of area in which the excavation activity is being performed;

F. The potential for serious incident should damage occur;

G. The prior history of the excavator with the operator; and

H. The potential for damage occurring which may not be easily recognized by the excavator.

[4.] **5.** The operator should pay particular attention, during and after excavation activities, to the possibility of joint leaks and breaks due to settlement when excavation activities occur near cast iron and threaded-coupled steel.

[5.] **6.** A damage prevention program under this subsection is not required for the following pipelines:

A. Pipelines to which access is physically controlled by the operator; and

B. Pipelines that are part of a petroleum gas system subject to subsection (1)(F) (192.11) or part of a distribution system operated by a person in connection with that person's leasing of real property or by a condominium or cooperative association.

7. Pipelines operated by persons other than municipalities (including operators of master meters) whose primary activity does not include the transportation of gas need not comply with the following:

A. The requirement of paragraph (12)(I)1. that the damage prevention program be written; and

B. The requirements of paragraphs (12)(I)3.A., (12)(I)3.B., and (12)(I)3.C.

(M) Maximum Allowable Operating Pressure—Steel or Plastic Pipelines. (192.619)

1. Except as provided in paragraph (12)(M)3., no person may operate a segment of steel or plastic pipeline at a pressure that exceeds the lowest of the following:

A. The design pressure of the weakest element in the segment, determined in accordance with sections (3) and (4).

However, for steel pipe in pipelines being converted under subsection (1)(H) or uprated under section (11), if any variable necessary to determine the design pressure under the design formula in subsection (3)(C) is unknown, one *[(1)]* of the following pressures is to be used as design pressure:

(I) Eighty percent (80%) of the first test pressure that produces yield under section N5.0 of Appendix N of ASME B31.8, reduced by the appropriate factor in (12)(M)1.B.(II); or

(II) If the pipe is twelve and three-quarter inches (12 3/4") **(324 mm)** or less in outside diameter and is not tested to yield under this paragraph, two hundred (200) psi*/g/* **(1379 kPa) gauge**;

B. The pressure obtained by dividing the highest pressure to which the segment was tested after construction or uprated as follows:

(I) For plastic pipe in all locations, the test pressure is divided by a factor of *[one point-five (1.5)]* **1.5**; and

(II) For steel pipe operated at one hundred (100) psi*/g/* **(689 kPa) gauge** or more, the test pressure is divided by a factor determined in accordance with the following table:

	Factors[1], segment—		
Class Location	Installed before (Nov. 12, 1970)	Installed after (Nov. 11, 1970)	Converted under *sub*section *(1)(H)* (192.14)
1	1.1	1.1	1.25
2	1.25	1.25	1.25
3	1.4	1.5	1.5
4	1.4	1.5	1.5

[1]For segments installed, uprated or converted after July 31, 1977 that are located on a platform in inland navigable waters, including a pipe riser, the factor is 1.5.

C. The highest actual operating pressure to which the segment was subjected during the five (5) years preceding July 1, 1970, unless the segment was tested in accordance with subparagraph (12)(M)1.B. after July 1, 1965, or the segment was uprated in accordance with section (11); and

D. The pressure determined by the operator to be the maximum safe pressure after considering the history of the segment, particularly known corrosion and the actual operating pressure.

2. No person may operate a segment of pipeline to which this subsection applies, unless overpressure protective devices are installed for the segment in a manner that will prevent the maximum allowable operating pressure from being exceeded, in accordance with subsection (4)(CC). (192.195)

3. Notwithstanding the other requirements of this subsection, an operator may operate a segment of pipeline found to be in satisfactory condition, considering its operating and maintenance history, at the highest actual operating pressure to which the segment was subjected during the five (5) years preceding July 1, 1970, subject to the requirements of subsection (12)(G). (192.611)

(N) Maximum Allowable Operating Pressure—High-Pressure Distribution Systems. (192.621)

1. No person may operate a segment of a high pressure distribution system at a pressure that exceeds the lowest of the following pressures, as applicable:

A. The design pressure of the weakest element in the segment, determined in accordance with sections (3) and (4);

B. Sixty (60) psi*/g/* **(414 kPa) gauge**, for a segment of a distribution system otherwise designated to operate at over sixty (60) psi*/g/* **(414 kPa) gauge**, unless the service lines in the segment are equipped with service regulators or other pressure limiting devices in series that meet the requirements of subsection (4)(DD) (192.197[c]);

C. Twenty-five (25) psi*/g/* **(172 kPa) gauge** in segments of cast iron pipe in which there are unreinforced bell and spigot joints;

D. The pressure limits to which a joint could be subjected without the possibility of its parting; and

E. The pressure determined by the operator to be the maximum safe pressure after considering the history of the segment, particularly known corrosion and the actual operating pressures.

2. No person may operate a segment of pipeline to which this subsection applies, unless overpressure protective devices are installed for the segment in a manner that will prevent the maximum allowable operating pressure from being exceeded, in accordance with subsection (4)(CC). (192.195)

(13) Maintenance.

(E) Line Markers for Mains and Transmission Lines. (192.707)

1. Buried pipelines. Except as provided in paragraph (13)(E)2., a line marker must be placed and maintained as close as practical over each buried main and transmission line—

A. At each crossing of a public road or railroad. Some crossings may require markers to be placed on both sides due to visibility limitations or crossing widths; and

B. Wherever necessary to identify the location of the transmission line or main to reduce the possibility of damage or interference.

2. Exceptions for buried pipelines. Line markers are not required for the following buried pipelines—

A. Mains and transmission lines located at crossings of or under waterways and other bodies of water;

B. Feeder lines and transmission lines located in Class 3 or Class 4 locations where placement of a marker is impractical; or

C. Mains other than feeder lines in Class 3 or Class 4 locations where a damage prevention program is in effect under (12)(I).

3. Pipelines aboveground. Line markers must be placed and maintained along each section of a main and transmission line that is located above ground.

4. Marker warning. The following must be written legibly on a background of sharply contrasting color on each line marker:

A. The word "Warning," "Caution" or "Danger," followed by the words "Gas (or name of gas transported) Pipeline" all of which, except for markers in heavily developed urban areas, must be in letters at least one inch (1") **(25 millimeters)** high with one-quarter inch (1/4") **(6.4 millimeters)** stroke; and

B. The name of the operator and telephone number (including area code) where the operator can be reached at all times.

(F) Record Keeping.

1. For transmission lines each operator shall keep records covering each leak discovered, repair made, line break, leakage survey, line patrol, and inspection for as long as the segment of transmission line involved remains in service. (192.709)

2. For feeder lines, mains, and service lines, each operator shall maintain—

A. Records pertaining to each original leak report for not less than six (6) years;

B. Records pertaining to each leak investigation and classification for not less than six (6) years. These records shall at least contain sufficient information to determine if proper assignment of the leak class was made, the promptness of actions taken, the address of the leak and the frequency of re-evaluation and/or reclassification;

C. Records pertaining to each leak repair for the life of the facility involved, except no record is required for repairs of aboveground Class 4 leaks. These records shall at least contain sufficient information to determine the promptness of actions taken, address of the leak, pipe condition at the leak site, leak classification at the time of repair and other such information necessary for proper

completion of DOT annual Distribution and Transmission Line report forms (RSPA F 7100.1-1 and RSPA F 7100.2-1); *[and]*

D. Records pertaining to leakage surveys and line patrols conducted over each segment of pipeline for not less than six (6) years. These records shall at least contain sufficient information to determine the frequency, scope and results of the leakage survey or line patrol*[.]* **; and**

E. Records pertaining to leak tests or surveys conducted in accordance with paragraph (14)(B)7. for not less than two (2) years.

3. For yard lines and buried fuel lines, each operator shall maintain records of notifications and leakage surveys required by subsection (13)(M) for not less than six (6) years.

(G) Transmission Lines—General Requirements for Repair Procedures. (192.711)

1. Each operator shall take immediate temporary measures to protect the public whenever—

A. A leak, imperfection or damage that impairs its serviceability is found in a segment of steel transmission line operating at or above forty percent (40%) of the SMYS; and

B. It is not feasible to make a permanent repair at the time of discovery. As soon as feasible the operator shall make permanent repairs.

2. Except as provided in subparagraph *[(13)(J)1.C. (192.717[a][3])]* **(13)(J)2.C. (192.717[b][3])**, no operator may use a welded patch as a means of repair.

(H) Transmission Lines—Permanent Field Repair of Imperfections and Damages. (192.713)

1. *[Except as provided in paragraph (13)(H)2., each]* **Each** imperfection or damage that impairs the serviceability of *[a segment of]* **pipe in a** steel transmission line operating at or above forty percent (40%) of SMYS must be *[repaired as follows:]—*

A. *[If it is feasible to take the segment out of service, the imperfection or damage must be removed]* **Removed** by cutting out **and replacing** a cylindrical piece of pipe *[and replacing it with pipe of similar or greater design strength]*; **or**

B. *[If it is not feasible to take the segment out of service, a full encirclement welded split sleeve of appropriate design must be applied over the imperfection or damage; and]* **Repaired by a method that reliable engineering tests and analyses show can permanently restore the serviceability of the pipe.**

[C.] **2.** *[If the segment is not taken out of service, the operating]* **Operating** pressure must be *[reduced to]* **at** a safe level during *[the]* repair operations.

[2. Submerged pipelines in inland navigable waters may be repaired by mechanically applying a full encirclement split sleeve of appropriate design over the imperfection or damage.]

(I) Transmission Lines—Permanent Field Repair of Welds. (192.715) Each weld that is unacceptable under paragraph (5)(I)3. (192.241[c]) must be repaired as follows:

1. If it is feasible to take the segment of transmission line out of service, the weld must be repaired in accordance with the applicable requirements of subsection (5)(K) (192.245);

2. A weld may be repaired in accordance with subsection (5)(K) (192.245) while the segment of transmission line is in service if—

A. The weld is not leaking;

B. The pressure in the segment is reduced so that it does not produce a stress that is more than twenty percent (20%) of the SMYS of the pipe; and

C. Grinding of the defective area can be limited so that at least one-eighth inch (1/8") **(3.2 millimeters)** thickness in the pipe weld remains; and

3. A defective weld which cannot be repaired in accordance with paragraph (13)(I)1. or 2. must be repaired by installing a full encirclement welded split sleeve of appropriate design.

(J) Transmission Lines—Permanent Field Repair of Leaks. (192.717)

[1. Except as provided in paragraph (13)(J) 2., each] **Each** permanent field repair of a leak on a transmission line must be made *[as follows:]* **by—**

[A.] **1.** *[If feasible, the segment of transmission line must be taken out of service and repaired]* **Removing the leak** by cutting out **and replacing** a cylindrical piece of pipe *[and replacing it with pipe of similar or greater design strength]*; **or**

2. Repairing the leak by one of the following methods:

[B.] **A.** *[If it is not feasible to take the segment of transmission line out of service, repairs must be made by installing]* **Install** a full encirclement welded split sleeve of appropriate design, unless the transmission line *[—*

(I) Is] **is** joined by mechanical couplings*[;]* and

[(II) Operates] **operates** at less than forty percent (40%) of SMYS*[; and]***.**

[C.] **B.** If the leak is due to a corrosion pit, *[the repair may be made by installing]* **install** a properly designed bolt-on-leak clamp *[or, if]***.**

C. If the leak is due to a corrosion pit and on pipe of not more than forty thousand (40,000) psi **(276 MPa)** SMYS, *[the repair may be made by fillet welding]* **fillet weld** over the pitted area a steel plate patch with rounded corners, of the same or greater thickness than the pipe, and not more than one-half (1/2) of the diameter of the pipe in size.

[2.] **D.** *[Submerged]* **If the leak is on a submerged** pipeline*[s]* in inland navigable waters**,** *[may be repaired by]* mechanically apply*[ing]* a full encirclement split sleeve of appropriate design *[over the leak]*.

E. Apply a method that reliable engineering tests and analyses show can permanently restore the serviceability of the pipe.

(O) Abandonment or Deactivation of Facilities. (192.727)

1. Each operator shall perform abandonment or deactivation of pipelines in accordance with the requirements of this subsection.

2. Each pipeline abandoned in place must be disconnected from all sources and supplies of gas, purged of gas; and sealed at the ends. However, the pipeline need not be purged when the volume of gas is so small that there is no potential hazard.

3. Except for service lines, each inactive pipeline that is not being maintained under this rule must be disconnected from all sources and supplies of gas, purged of gas; and sealed at the ends. However, the pipeline need not be purged when the volume of gas is so small that there is no potential hazard.

4. Whenever service to a customer is discontinued, one (1) of the following must be complied with:

A. The valve that is closed to prevent the flow of gas to the customer must be provided with a locking device or other means designed to prevent the opening of the valve by persons other than those authorized by the operator;

B. A mechanical device or fitting that will prevent the flow of gas must be installed in the service line or in the meter assembly; or

C. The customer's piping must by physically disconnected from the gas supply and the open pipe ends sealed.

5. If air is used for purging, the operator shall ensure that a combustible mixture is not present after purging.

6. Each abandoned vault must be filled with a suitable compacted material.

7. For each abandoned pipeline facility that crosses over, under or through a commercially navigable waterway, the last operator of that facility must file a report upon abandonment

of that facility. The addresses (mail and E-mail) and phone numbers given in this paragraph are from section 192.727(g) of 49 CFR part 192, which became effective on October 10, 2000. Please consult the current edition of 49 CFR part 192 for any updates to these addresses and phone numbers.

A. The preferred method to submit data on pipeline facilities abandoned after October 10, 2000 is to the National Pipeline Mapping System (NPMS) in accordance with the NPMS "Standards for Pipeline and Liquefied Natural Gas Operator Submissions." To obtain a copy of the NPMS Standards, please refer to the NPMS homepage at www.npms.rspa.dot.gov or contact the NPMS National Repository at 703-317-3073. A digital data format is preferred, but hard copy submissions are acceptable if they comply with the NPMS Standards. In addition to the NPMS-required attributes, operators must submit the date of abandonment, diameter, method of abandonment, and certification that, to the best of the operator's knowledge, all of the reasonably available information requested was provided and, to the best of the operator's knowledge, the abandonment was completed in accordance with applicable laws. Refer to the NPMS Standards for details in preparing your data for submission. The NPMS Standards also include details of how to submit data. Alternatively, operators may submit reports by mail, fax or E-mail to the Information Officer, Research and Special Programs Administration, Department of Transportation, Room 7128, 400 Seventh Street, SW, Washington DC 20590; fax (202) 366-4566; E-mail, roger.little@rspa.dot.gov. The information in the report must contain all reasonably available information related to the facility, including information in the possession of a third party. The report must contain the location, size, date, method of abandonment, and a certification that the facility has been abandoned in accordance with all applicable laws.

B. Data on pipeline facilities abandoned before October 10, 2000 must be filed before April 10, 2001. Operators may submit reports by mail, fax or E-mail to the Information Officer, Research and Special Programs Administration, Department of Transportation, Room 7128, 400 Seventh Street, SW, Washington DC 20590; fax (202) 366-4566; E-mail, roger.little@rspa.dot.gov. The information in the report must contain all reasonably available information related to the facility, including information in the possession of a third party. The report must contain the location, size, date, method of abandonment, and a certification that the facility has been abandoned in accordance with all applicable laws.

(Q) Compressor Stations—Storage of Combustible Materials and Gas Detection. (192.735 and 192.736)

1. Flammable or combustible materials in quantities beyond those required for everyday use, or other than those normally used in compressor buildings, must be stored a safe distance from the compressor building.

2. Aboveground oil or gasoline storage tanks must be protected in accordance with the *Flammable and Combustible Liquids Code*, ANSI/NFPA 30.

3. Not later than September 16, 1996, each compressor building in a compressor station must have a fixed gas detection and alarm system, unless the building is—

A. Constructed so that at least fifty percent (50%) of its upright side area is permanently open; or

B. Located in an unattended field compressor station of one thousand (1,000) horsepower **(746 kW)** or less.

4. Except when shutdown of the system is necessary for maintenance under paragraph (13)(Q)5., each gas detection and alarm system required by this subsection must—

A. Continuously monitor the compressor building for a concentration of gas in air of not more than twenty-five percent (25%) of the lower explosive limit; and

B. If gas at that concentration is detected, warn persons about to enter the building and persons inside the building of the danger.

5. Each gas detection and alarm system required by this subsection must be maintained to function properly. The maintenance must include performance tests.

(W) Vault Maintenance. (192.749)

1. Each vault housing pressure regulating and pressure limiting equipment**,** and having a volumetric internal content of two hundred (200) cubic feet **(5.66 cubic meters)** or more must be inspected at intervals not exceeding fifteen (15) months but at least once each calendar year to determine that it is in good physical condition and adequately ventilated.

2. If gas is found in the vault, the equipment in the vault must be inspected for leaks, and any leaks found must be repaired.

3. The ventilating equipment must also be inspected to determine that it is functioning properly.

4. Each vault cover must be inspected to assure that it does not present a hazard to public safety.

(Y) Caulked Bell and Spigot Joints. (192.753)

1. Each cast iron caulked bell and spigot joint that is subject to pressures of twenty-five (25) psi*[g]* **(172 kPa) gauge** or more must be sealed with—

A. A mechanical leak clamp; or

B. A material or device which—

(I) Does not reduce the flexibility of the joint;

(II) Permanently bonds, either chemically or mechanically, or both, with the bell and spigot metal surfaces or adjacent pipe metal surfaces; and

(III) Seals and bonds in a manner that meets the strength, environmental and chemical compatibility requirements of paragraphs (2)(B)1. and 2. and subsection (4)(B). (192.53 (a) and (b) and 192.143)

2. Each cast iron caulked bell and spigot joint that is subject to pressures of less than twenty-five (25) psi*[g]* **(172 kPa) gauge** and is exposed for any reason must be sealed by a means other than caulking.

(14) Gas Leaks.

(B) Investigation and Classification Procedures.

1. Each operator-detected leak indication or any leak or odor call from the general public, police, fire or other authorities or notification of damage to facilities by contractors or other outside sources shall require immediate investigation and classification.

2. Investigation of each inside leak or odor notice shall include the use of gas detection equipment upon initial entry into the structure and during investigations within the structure. When investigating an outside leak or odor notice, special attention must be given to those situations where conditions could impair the venting of natural gas to the atmosphere or impair the ability of gas detection equipment to properly detect the presence of gas, such as excessive ground moisture, rain, snow, frozen soil or wind.

3. Investigation of underground leaks shall be conducted using gas detection equipment. Sampling of the subsurface atmosphere shall be done at sufficient intervals and locations to assure safety to persons and property in the immediate and adjacent area.

4. Except for obvious Class 1 leaks, all leak classifications shall be substantiated by the use of gas detection equipment.

5. A follow-up leak investigation shall be conducted immediately after the repair of each Class 1 or Class 2 leak, and continued as necessary, to determine the effectiveness of the repair and to assure all hazardous leaks in the affected area are corrected.

6. Whenever the operator conducts work on a customer's premises for any type of customer gas service order or call, including all premises odor calls, tests of the subsurface atmosphere must be made using gas detection equipment, except as noted below. At least one *[(1)]* test must be made at a location where the buried service line or yard line is near the structure; for copper service

lines, at least one *[(1)]* additional test must be made at the customer's property line, approximately one hundred feet (100') from the structure, or at the service tap at the main, whichever is closest to the structure. In lieu of conducting the tests of the subsurface atmosphere, the operator may conduct a leak survey of this pipe with gas detection equipment capable of detecting gas concentrations of three hundred (300) parts per million, gas-in-air. These tests are not required for collections, discontinuance of service for nonpayment, meter readings, read-ins/read-outs, line locations, atmospheric corrosion protection work or general painting, when relighting after emergency outages or curtailments, when lighting customer pilot lights *[as part of a pilot lighting program]*, cathodic protection work, or if leak tests have been conducted at the location within the previous fifteen (15) months.

AUTHORITY: sections 386.250, [and] 386.310, [RSMo Supp. 1997] and 393.140, RSMo [1994] 2000. Original rule filed Feb. 23, 1968, effective March 14, 1968. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file comments in support of or in opposition to this proposed amendment with the Missouri Public Service Commission, Dale Hardy Roberts, Secretary, P.O. Box 360, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. Comments should refer to Case No. GX-2001-91 and be filed with an original and eight (8) copies. No public hearing is scheduled.*

Appendix A—4 CSR 240-40.030

Appendix A—Incorporated by Reference

I. List of organizations and address.

A. American Gas Association (AGA), 1515 Wilson Boulevard, Arlington, VA 22209.

B. American National Standards Institute (ANSI), 11 West 42nd Street, New York, NY 10036.

C. American Petroleum Institute (API), 1220 L Street N.W., Washington, D.C. 20005.

D. The American Society of Mechanical Engineers (ASME), United Engineering Center, 345 East 47th Street, New York, NY 10017.

E. American Society for Testing and Materials (ASTM), 100 Barr Harbor Drive, West Conshohocken, PA 19428.

F. Manufacturers Standardization Society of the Valve and Fittings Industry, Inc. (MSS), 127 Park Street, N.W., Vienna, VA 22180.

G. National Fire Protection Association (NFPA), 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101.

II. Documents incorporated by reference. Numbers in parentheses indicate applicable editions.

A. American Gas Association (AGA):

1) AGA Pipeline Research Committee, Project PR-3-805, *A Modified Criterion for Evaluating the Remaining Strength of Corroded Pipe* (December 22, 1989).

B. American Petroleum Institute (API):

1) API Specification 5L *Specification for Line Pipe* (41st edition 1995).

2) API Recommended Practice 5L1 *Recommended Practice for Railroad Transportation of Line Pipe* (4th edition, 1990).

3) API Specification 6D *Specification for Pipeline Valves (Gate, Plug, Ball, and Check Valves)* (21st edition, 1994).

4) API Standard 1104 *Welding of Pipelines and Related Facilities (*18th edition, 1994).

C. The American Society for Testing and Materials (ASTM):

1) ASTM Designation A 53 *Standard Specification for Pipe, Steel, Black and Hot-Dipped, Zinc-Coated, Welded and Seamless* (A 53-*[95a]* **96**).

2) ASTM Designation A 106 *Standard Specification for Seamless Carbon Steel Pipe for High-Temperature Service* (A 106-*[94a]* **95**).

3) ASTM Designation A 671 *Standard Specification for Electric-Fusion-Welded Steel Pipe for Atmospheric and Lower Temperatures* (A 671-94).

4) ASTM Designation A 672 *Standard Specification for Electric-Fusion-Welded Steel Pipe for High-Pressure Service at Moderate Temperatures* (A 672-94).

5) ASTM Designation A 691 *Standard Specification for Carbon and Alloy Steel Pipe, Electric-Fusion-Welded for High-Pressure Service at High Temperatures* (A 691-93).

6) ASTM Designation A 333/A 333M *Standard Specification for Seamless and Welded Steel Pipe for Low Temperature Service* (A 333/A 333M-94).

7) ASTM Designation A 372/A 372M *Standard Specification for Carbon and Alloy Steel Forgings for Thin-Walled Pressure Vessels* (A 372/A 372M-95).

8) ASTM Designation A 381 *Standard Specification for Metal-Arc-Welded Steel Pipe for Use with High-Pressure Transmission Systems* (A 381-93).

9) ASTM Designation D 638 *Standard Test Method for Tensile Properties of Plastics* (D 638-*[95]* **96**).

10) ASTM Designation D 2513 *Standard Specification for Thermoplastic Gas Pressure Pipe, Tubing, and Fittings* (D 2513-87 edition for subparagraph (2)(E)1.A., otherwise D 2513-*[95c]* **96a**).

11) ASTM Designation D 2517 *Standard Specification for Reinforced Epoxy Resin Gas Pressure Pipe and Fittings* (D 2517-94).

12) ASTM Designation F 1055 *Standard Specification for Electrofusion Type Polyethylene Fittings for Outside Diameter Controlled Polyethylene Pipe and Tubing* (F 1055-95).

D. The American Society of Mechanical Engineers (ASME):

1) ASME/ANSI B16.1 *Cast-Iron Pipe Flanges and Flanged Fittings* (1989).

2) ASME/ANSI B16.5 *Pipe Flanges and Flanged Fittings* (1988 with October 1988 Errata and ASME/ANSI B16.5a-1992 Addenda).

3) ASME/ANSI B31G *Manual for Determining the Remaining Strength of Corroded Pipelines* (1991).

4) ASME/ANSI B31.8 *Gas Transmission and Distribution Piping Systems* (1995).

5) ASME Boiler and Pressure Vessel Code, Section I *Power Boilers* (1995 edition with 1995 Addenda).

6) ASME Boiler and Pressure Vessel Code, Section VIII, Division 1 *Pressure Vessels* (1995 edition with 1995 Addenda).

7) ASME Boiler and Pressure Vessel Code, Section VIII, Division 2 *Pressure Vessels: Alternative Rules* (1995 edition with 1995 addenda).

8) ASME Boiler and Pressure Vessel Code, Section IX, *Welding and Brazing Qualifications* (1995 edition with 1995 Addenda).

E. Manufacturer's Standardization Society of the Valve and Fittings Industry, Inc. (MSS):

1) MSS SP-44-**1996** *Steel Pipe Line Flanges* **(includes 1996 errata)** (*[1991]* **1996**).

F. National Fire Protection Association (NFPA):

1) ANSI/NFPA 30 *Flammable and Combustible Liquids Code* (*[1993]* **1996**).

2) *Reserved*

3) ANSI/NFPA 58 *Standard for the Storage and Handling of Liquefied Petroleum Gases* (1995).

4) ANSI/NFPA 59 *Standard for the Storage and Handling of Liquefied Petroleum Gases at Utility Gas Plants* (1995).

5) ANSI/NFPA 70 *National Electrical Code* (1996).

Appendix B to 4 CSR 240-40.030

Appendix B—Qualification of Pipe

I. Listed Pipe Specifications. Numbers in parentheses indicate applicable editions.

API 5L—Steel pipe (1995).

ASTM A 53—Steel pipe (*[1995a]* **1996**).

ASTM A 106—Steel pipe (*[1994a]* **1995**).

ASTM A 333/A 333M—Steel pipe (1994).

ASTM A 381—Steel pipe (1993).

ASTM A 671—Steel pipe (1994).

ASTM A 672—Steel pipe (1994).

ASTM A 691—Steel pipe (1993).

ASTM D 2513—Thermoplastic pipe and tubing (*[1995c]* **1996a**).

ASTM D 2517—Thermosetting plastic pipe and tubing (1994).

II. Steel pipe of unknown or unlisted specification.

A. Bending properties. For pipe two inches (2") **(51 millimeters)** or less in diameter, a length of pipe must be cold bent through at least ninety degrees (90°) around a cylindrical mandrel that has a diameter twelve (12) times the diameter of the pipe, without developing cracks at any portion and without opening the longitudinal weld. For pipe more than two inches (2") **(51 millimeters)** in diameter, the pipe must meet the requirements of the flattening tests set forth in ASTM A53, except that the number of tests must be at least equal to the minimum required in paragraph II.D. of this appendix to determine yield strength.

B. Weldability. A girth weld must be made in the pipe by a welder who is qualified under section (5) of 4 CSR 240-40.030. The weld must be made under the most severe conditions under which welding will be allowed in the field and by means of the same procedure that will be used in the field. On pipe more than four inches (4") **(102 millimeters)** in diameter, at least one *[(1)]* test weld must be made for each one hundred (100) lengths of pipe. On pipe four inches (4") **(102 millimeters)** or less in diameter, at least one *[(1)]* test weld must be made for each four hundred (400) lengths of pipe. The weld must be tested in accordance with API Standard 1104. If the requirements of API Standard 1104 cannot be met, weldability may be established by making chemical tests for carbon and manganese, and proceeding in accordance with section IX of the *ASME Boiler and Pressure Vessel Code*. The same number of chemical tests must be made as are required for testing a girth weld.

C. Inspection. The pipe must be clean enough to permit adequate inspection. It must be visually inspected to ensure that it is reasonably round and straight and there are no defects which might impair the strength or tightness of the pipe.

D. Tensile properties. If the tensile properties of the pipe are not known, the minimum yield strength may be taken as twenty-four thousand (24,000) psi **(165 MPa)** or less, or the tensile properties may be established by performing tensile tests as set forth in API Specification 5L. All test specimens shall be selected at random and the following number of tests must be performed:

Number of Tensile Tests–All Sizes	
10 lengths or less	1 set of tests for each length.
11 to 100 lengths	1 set of tests for each 5 lengths, but not less than 10 tests.
Over 100 lengths	1 set of tests for each 10 lengths, but not less than 20 tests.

If the yield-tensile ratio, based on the properties determined by those tests, exceeds 0.85, the pipe may be used only as provided in paragraph (2)(C)3. of 4 CSR 240-40.030. (192.55[c])

III. Steel pipe manufactured before November 12, 1970 to earlier editions of listed specifications. Steel pipe manufactured before November 12, 1970, in accordance with a specification of which a later edition is listed in section I. of this appendix, is qualified for use under this rule if the following requirements are met:

A. Inspection. The pipe must be clean enough to permit adequate inspection. It must be visually inspected to ensure that it is reasonably round and straight and that there are no defects which might impair the strength or tightness of the pipe; and

B. Similarity of specification requirements. The edition of the listed specification under which the pipe was manufactured must have substantially the same requirements with respect to the following properties as a later edition of that specification listed in section I. of this appendix:

1) Physical (mechanical) properties of pipe, including yield and tensile strength, elongation and yield to tensile ratio, and testing requirements to verify those properties.

2) Chemical properties of pipe and testing requirements to verify those properties.

C. Inspection or test of welded pipe. On pipe with welded seams, one (1) of the following requirements must be met:

1) The edition of the listed specification to which the pipe was manufactured must have substantially the same requirements with respect to nondestructive inspection of welded seams and the standards for acceptance or rejection and repair as a later edition of the specification listed in section I. of this appendix; or

2) The pipe must be tested in accordance with section (10) of 4 CSR 240-40.030 to at least one and one-fourth (1.25) times the maximum allowable operating pressure if it is to be installed in a Class 1 location and to at least one and one-half (1.5) times the maximum allowable operating pressure if it is to be installed in a Class 2, 3 or 4 location. Notwithstanding any shorter time period permitted under section (10) of 4 CSR 240-40.030, the test pressure must be maintained for at least eight (8) hours.

Appendix C to 4 CSR 240-40.030

Appendix C—Qualification of Welders for Low Stress Level Pipe

I. Basic Test. The test is made on pipe twelve inches (12") **(305 millimeters)** or less in diameter. The test weld must be made with the pipe in a horizontal fixed position so that the test weld includes at least one *[(1)]* section of overhead position welding. The beveling, root opening and other details must conform to the specifications of the procedure under which the welder is being qualified. Upon completion, the test weld is cut into four *[(4)]* coupons and subjected to a root bend test. If, as a result of this test, two *[(2)]* or more of the four *[(4)]* coupons develop a crack in the weld material, or between the weld material and base metal, that is more than one-eighth inch (1/8") **(3.2 millimeters)** long in any direction, the weld is unacceptable. Cracks that occur on the corner of the specimen during testing are not considered.

II. Additional tests for welders of service line connections to mains. A service line connection fitting is welded to a pipe section with the same diameter as a typical main. The weld is made in the same position as it is made in the field. The weld is unacceptable if it shows a serious undercutting or if it has rolled edges. The weld is tested by attempting to break the fitting off the run pipe. The weld is unacceptable if it breaks and shows incomplete fusion, overlap or poor penetration at the junction of the fitting and run pipe.

III. Periodic tests for welders of small service lines. Two *[(2)]* samples of the welder's work, each about eight inches (8") **(203 millimeters)** long with the weld located approximately in the center, are cut from steel service line and tested as follows:

1) One *[(1)]* sample is centered in a guided bend testing machine and bent to the contour of the die for a distance of two inches (2") **(51 millimeters)** on each side of the weld. If the sample shows any breaks or cracks after removal from the bending machine, it is unacceptable; and

2) The ends of the second sample are flattened and the entire joint subjected to a tensile strength test. If failure occurs adjacent to or in the weld metal, the weld is unacceptable. If a tensile strength testing machine is not available, this sample must also pass the bending test prescribed in paragraph III.1) of this appendix.

Appendix E to 4 CSR 240-40.030

Appendix E. Table of Contents—Safety Standards—Transportation of Gas by Pipeline.

4 CSR 240-40.030(8) Customer Meters, Service Regulators and Service Lines

(A) Scope, Compliance with Specifications or Standards, and Inspections. (192.351)

(B) Service Lines and Yard Lines.

(C) Customer Meters and Regulators—Location. (192.353)

(D) Customer Meters and Regulators—Protection From Damage. (192.355)

(E) Customer Meters and Regulators—Installation. (192.357)

(F) Customer Meter Installations—Operating Pressure. (192.359)

(G) Service Lines—Installation. (192.361)

(H) Service Lines—Valve Requirements. (192.363)

(I) Service Lines—Location of Valves. (192.365)

(J) Service Lines—General Requirements for Connections to Main Piping. (192.367)

(K) Service Lines—Connections to Cast Iron or Ductile Iron Mains. (192.369)

(L) Service Lines—Steel. (192.371)

(M) Service Lines—Plastic. (192.375)

(N) New Service Lines Not in Use. (192.379)

(O) Service Lines—Excess Flow Valve Performance Standards. (192.381)

(P) Excess Flow Valve Customer Notification. (192.383)

4 CSR 240-40.030(10) Test Requirements

(A) Scope. (192.192.501)

(B) General Requirements. (192.503)

(C) Strength Test Requirements for Steel Pipelines to Operate at a Hoop Stress of Thirty Percent (30%) or More of SMYS. (192.505)

(D) Test Requirements for Pipelines to Operate at a Hoop Stress Less Than Thirty Percent (30%) of SMYS and **at or** Above One Hundred (100) psi*/g/* **(689 kPa) gauge**. (192.507)

(E) Test Requirements for Pipelines to Operate *[at or]* Below One Hundred (100) psi*/g/* **(689 kPa) gauge**. (192.509)

(F) Test Requirements for Service Lines. (192.511)

(G) Test Requirements for Plastic Pipelines. (192.513)

(H) Environmental Protection and Safety Requirements. (192.515)

(I) Records. (192.517)

(J) Test Requirements for Customer-Owned Fuel Lines.

4 CSR 240-40.030(12) Operations.

(A) Scope. (192.601)

(B) General Provisions. (192.603)

(C) Procedural Manual for Operations, Maintenance, and Emergencies. (192.605)

(D) *[Personnel]* Qualification **of Pipeline Personnel (Subpart N)**.

(E) *Reserved* (192.607)

(F) Change in Class Location—Required Study. (192.609)

(G) Change in Class Location—Confirmation or Revision of Maximum Allowable Operating Pressure. (192.611)

(H) Continuing Surveillance. (192.613)

(I) Damage Prevention Program. (192.614)

(J) Emergency Plans. (192.615)

(K) Public Education. (192.616)

(L) Investigation of Failures. (192.617)

(M) Maximum Allowable Operating Pressure—Steel or Plastic Pipelines. (192.619)

(N) Maximum Allowable Operating Pressure—High-Pressure Distribution Systems. (192.621)

(O) Maximum and Minimum Allowable Operating Pressure—Low-Pressure Distribution Systems. (192.623)

(P) Odorization of Gas. (192.625)

(Q) Tapping Pipelines Under Pressure. (192.627)

(R) Purging of Pipelines. (192.629)

(S) Providing Service to Customers.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 265—Division of Motor Carrier and Railroad Safety
Chapter 10—Motor Carrier Operations

PROPOSED AMENDMENT

4 CSR 265-10.030 Insurance. The division is amending the Purpose clause, inserting new sections (1) and (2), amending and renumbering current sections (1), (2), (3), (4), (6), (7) and (10), amending and renumbering current section (5) as subsection (A) of section (6), and amending section (9). Sections (8), (11), (12), and (13) are deleted entirely, but their subject matter is being revised and addressed in other sections of the rule as amended.

PURPOSE: The division finds that this amendment is necessary to carry out the following purposes: (1) To implement the requirements and provisions of section 390.128 of section A of House Bill No. 1797, 90th Missouri General Assembly, 2nd Regular Session (effective August 28, 2000), by providing for the electronic filing of proof of insurance for motor carriers operating under the division's authority within the state; (2) To enable the division to continue carrying out its duties in registering interstate motor carriers under section 390.071, RSMo, by quickly adapting to imminent changes in the relevant federal regulations pursuant to the single, federal on-line registration system mandated by Congress in section 13908 of title 49, ***United States Code****; (3) To enhance the ability and convenience of the motor carrier and insurance industries to comply with this rule and section 390.126, RSMo, by replacing the 15-day FAX binder authorization with provisions allowing the filing of FAX copies as final documents instead of originals; (4) To streamline or clarify the rule, and to increase compatibility with corresponding federal motor carrier insurance requirements, through text revisions that include: (a) adding topical subheadings for each section; (b) advancing the definitions from the end to the beginning of the rule; (c) adding pertinent definitions of terms defined in corresponding federal laws or regulations; (d) updating references to the relevant federal agency, laws, regulations, and the Single State Registration System, which are either obselete, or subject to imminent changes already approved by act of Congress; (e) explaining certain procedures that were merely implied or unclear in the existing rule; (f) clarifying that cargo insurance requirements are applicable only to the transportation of household goods; (g) avoiding redundant use of terms or phrases; (h) replacing text in the passive voice with the active voice when appropriate; (i) removing unnecessary plurals when singular word forms are sufficient; and (j) condensing the text when more concise wording can be used instead.*

PURPOSE: This rule [prescribes the amounts and filing requirements for insurance] ***defines and describes the procedures, forms and authorization for filing, canceling, replacing and reinstating proof of motor carrier insurance or surety bonds, and prescribes the minimum limits of public liability coverage for motor carriers of passengers or property, and minimum limits of cargo liability coverage for household goods carriers****.*

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) Definitions. As used in this rule, unless the context clearly indicates otherwise, the following words and terms mean:

(A) Bodily injury—Injury to the body, sickness, or disease, including death resulting from any of these.

(B) Cancellation—The termination of insurance coverage by either the insurer or the insured.

(C) Endorsement—A written amendment to the insurance policy.

(D) FMCSA—Federal Motor Carrier Safety Administration, including any successor agency or official that hereafter is authorized by federal law to administer the licensing of interstate motor carriers.

(E) Form—The standard form document that is currently specified for use by the division, including any electronic forms or data that may be approved by the division as acceptable equivalents pursuant to this rule or section 390.128, RSMo. Forms E, F, G, H, I, J, K and L referred to in this rule are incorporated by reference in this rule. The division may add, amend, or eliminate any standard forms, which may include joint or common forms used by the division in cooperation with other public governmental agencies or officials.

(F) Property damage—Damage to or loss of use of tangible property, except property that the carrier transports as cargo on its motor vehicle.

(G) Public liability—Liability for bodily injury or property damage; and with reference to the transportation of property in interstate commerce pursuant to authority granted by the FMCSA, or the transportation of any hazardous material, hazardous substance or hazardous waste in interstate or intrastate commerce, the term includes liability for environmental restoration.

(H) SSRS—The Single State Registration System established pursuant to section 14504 of title 49, *United States Code*, and part 365 of title 49, *Code of Federal Regulations*, including any successor motor carrier registration system that may be created pursuant to section 13908 of title 49, *United States Code*, and any federal regulations implementing that section, as those statutes and regulations have been or periodically may be amended.

(2) Filing of Documents. Insurance companies offering motor carrier insurance certificates, surety bonds, cancellation notices, or other documents for filing with the division pursuant to this rule, shall deliver the documents to the attention of the division's registration section, in the division's main office, by any of the following methods: personal delivery, U.S. mail, express courier delivery, and unless otherwise specifically ordered by the division, photocopies or FAX copies may be offered for filing instead of originals. Whenever the division determines that it has the capability, it may also receive and accept or reject these documents for filing through any national clearinghouse or private database, electronic mail (E-mail), or other approved electronic media, in conformity with section (10) of this rule. A person or company that offers photocopies, FAX copies, or electronic documents for filing shall be bound by them as if they were signed originals. All documents offered for filing shall comply with the applicable requirements and be properly signed or otherwise authenticated in accordance with this rule.

(A) Upon request, the division will acknowledge receipt of any document offered for filing pursuant to this rule by stamping or marking the document, or other method approved by the division, which shall specify the date when received. The division shall receive these documents between the hours of 8:00 a.m. and 5:00 p.m. daily, except on Saturdays, Sundays and state holidays. If any document is received by the division by FAX, E-mail, or any other electronic medium on a Saturday, Sunday or state holiday, or on any other day after 5:00 p.m. but before 8:00 a.m. on the next succeeding day, then the division shall deem it as received at 8:00 a.m. on the next succeeding day that is neither a Saturday, Sunday, nor state holiday.

(B) A document offered for filing pursuant to this rule is filed with the division when the designated division personnel have—

1. Received the completed document;

2. Made a preliminary review and determination that the document received is complete, properly authenticated, and satisfies all applicable legal requirements; and

3. Confirmed the filing by stamping or marking the document, or other method approved by the division, which shall record the date when filed.

(C) Except as provided in section (10) of this rule, whenever a document form is specified by this rule, the document shall be filed using that form.

(D) The division may reject any document filed or offered for filing pursuant to this rule, or declare it invalid at any time, and shall notify the motor carrier of the rejection or invalidity, if —

1. The motor carrier fails to comply, or to obtain compliance by its insurer or surety, with any applicable requirement of the division pursuant to this rule, section 390.126, or section 390.128, RSMo;

2. The person or persons purporting to have signed or authenticated the document fail to give the division adequate assurance of the authenticity of the document, including any signatures or copies, when requested by the division; or

3. The document is filed on paper that is either larger than eight and one-half inches wide by eleven inches high (8 1/2" × 11"), or smaller than eight and one-half inches wide by five and one-half inches high (8 1/2" × 5 1/2").

(E) Insurance certificates and surety bonds filed with the division shall not be removed from the division's custody, except as provided by law or by permission of the division director or personnel authorized by the director.

*[(1)]***(3) Proof of Coverage and Minimum Limits of Public Liability for Intrastate Carriers Generally.** Except as provided in section *[(2)]***(4)**, every motor carrier operating **any** motor vehicles in intrastate commerce by authority of *[the Division of Motor Carrier and Railroad Safety]* **this division** shall at all times have on file with and approved by the division a surety bond or a certificate of public liability *[and property damage]* insurance (on a form approved by the division) which shall show specifically that the required uniform endorsements are attached to the policy covering each motor vehicle in amounts not less than the following amounts:

(A) Passenger vehicles—twelve (12)-passenger or less capacity, $100,000 for injury or death of one (1) person; $300,000 for any one (1) accident; $50,000 property damage for any one (1) accident. More than twelve (12)-passenger capacity, $100,000 for injury or death of one (1) person; $500,000 for any one (1) accident; $50,000 property damage for any one (1) accident; and

(B) Freight vehicles—$100,000 for injury or death of one (1) person; $300,000 for any one (1) accident; $50,000 property damage for any one (1) accident.

*[(2)]***(4) Proof of Coverage and Minimum Limits of Public Liability for Interstate or Hazardous Materials Carriers.** Every motor carrier operating **any** motor vehicles in interstate commerce in or through Missouri, and every motor carrier operating **any** motor vehicles in intrastate commerce transporting those types of commodities designated in the following table, at all times shall have on file with and approved by the division a surety bond or a certificate of public liability *[(bodily injury) and property damage]* insurance; except that**, before operating any motor vehicles within this state,** a motor carrier whose Missouri vehicle operations are exclusively in interstate commerce under *[Interstate Commerce Commission (ICC) or Federal Highway Administration (FHWA)]* **FMCSA** authority shall file proof of insurance with its registration state as required by the *Single State Registration System (SSRS) Procedures Manual* which is incorporated by reference in this rule*[.]***, or in accordance with any succeeding SSRS requirements. Except as otherwise required to comply with SSRS,** *[E]***e**very surety bond and insurance certificate **filed pursuant to this section** shall show specifically that the required uniform endorsements are attached to the policy covering each motor vehicle in amounts not less than the amounts depicted on the following table:

SCHEDULE OF *MINIMUM* LIMITS *OF PUBLIC LIABILITY*
[(Public Liability and Property Damage Insurance)]

Type of Carriage	Commodity Transported	Amount
1) Motor carriers operating in interstate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Property (nonhazardous)	$ 750,000
2) Motor carriers operating in interstate commerce or intrastate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Hazardous substances, as defined in 49 CFR 171.8, transported in cargo tanks, portable tanks or hopper-type vehicles with capacities in excess of 3,500 water gallons; or in bulk[1] Division 1.1, 1.2 and 1.3 materials, Division 2.3, Hazard Zone A, or Division 6.1, Packing Group I, Hazard Zone A materials; or in bulk Division 2.1 or 2.2; or highway route controlled quantities of a Class 7 material as defined in 49 CFR 173.403	$5,000,000
3) Motor carriers operating in interstate commerce or intrastate commerce, with a gross vehicle weight rating of 10,000 or more pounds	Oil listed in 49 CFR 172.101; hazardous waste, hazardous materials and hazardous substances defined in 49 CFR 171.8 and listed in 49 CFR 172.101, but not mentioned in 2) or 4)	$1,000,000
4) Motor carriers operating in interstate commerce, with a gross vehicle weight rating of LESS THAN 10,000 pounds	Any quantity of Division 1.1, 1.2 or 1.3 material; any quantity of Division 2.3 Hazard Zone A or Division 6.1, Packing Group I Hazard Zone A material; or highway route controlled quantities of a Class 7 material as defined in 49 CFR 173.403	$5,000,000
5) Motor carriers operating in interstate commerce	Passengers—Any vehicle with a seating capacity of 16 passengers or more	$5,000,000
	Passengers—Any vehicle with a seating capacity of 15 passengers or less	$1,500,000

[1] NOTE: As used in row number 2) of the above table, the following definitions apply:

"In bulk" means the transportation, as cargo, of property, except Division 1.1, 1.2 or 1.3 materials, and Division 2.3, Hazard Zone A gases, in containment systems with capacities in excess of 3,500 water gallons;

"In bulk" (Division 1.1, 1.2 and 1.3 explosives) means the transportation, as cargo, of any Division 1.1, 1.2 or 1.3 materials in any quantity; and

"In bulk" (Division 2.3, Hazard Zone A, or Division 6.1, Packing Group I, Hazard Zone A materials) means the transportation, as cargo, of any Division 2.3, Hazard Zone A or Division 6.1, Packing Group I, Hazard Zone A material in any quantity.

*[(3)]***(5) Public Liability Insurance and Surety Bond Forms.** The certificate of **public liability** insurance (form E) shall state that the insurer has issued to the motor carrier a policy of insurance which by endorsement provides automobile bodily injury and property damage liability insurance covering the obligations imposed upon the motor carrier by the provisions of the law of this state. The certificate shall be on form E—Uniform Motor Carrier Bodily Injury *[A]***a**nd Property Damage Liability Certificate of Insurance. The certificate shall be duly completed and executed by the insurer. The endorsement*[s]* shall be attached to the insurance policy and *[shall]* form a part of it *[and true]***. True** copies of the policy with the endorsement*[s]* attached shall be maintained at the motor carrier's principal place of business *[(if any)]***, and upon request shall be produced for inspection by the division** within this state. The endorsement*[s]* shall be on form F—Uniform Motor Carrier Bodily Injury and Property Damage Liability Insurance Endorsement*[s]*. The endorsement*[s]* shall be duly completed and executed by the insurer. The form F endorsement amends the insurance policy to which it is attached to assure compliance with this rule by the motor carrier. The surety bond shall be in the form set forth in form G—Uniform Motor Carrier Bodily Injury *[A]***a**nd Property Damage Surety Bond. The bond shall be duly completed and executed by the surety and principal. *[The division shall accept, as a fifteen (15)-day binder pending the receipt of the original form, legible copies of forms E and G filed with the division by telephonic (fax) transmission. If the original form is not received by the division within fifteen (15) days after receipt of the fax, then the carrier is not in compliance with this section and the division will accept only the original form.]* **Except as otherwise required pursuant to SSRS, this section is applicable to interstate as well as intrastate motor carriers.**

*[(4)]***(6) Intrastate Household Goods Cargo Liability—Proof of Coverage, Minimum Limits and Forms.** Except as otherwise provided in this rule or by division order, each *[freight-carrying]* vehicle while transporting household goods in intrastate commerce within this state shall be covered by a surety bond or certificate of cargo insurance filed with, and approved by, the division in amounts not less than the following: for loss or damage to *[property carried]* **household goods cargo** on any one (1) motor vehicle—$2**,**500; for loss or damage to or aggregate of losses or damages of or to *[property]* **household goods cargo** occurring at any one (1) time and place—$5**,**000.

[(A) Any shipper and contract carrier may agree upon different limits of cargo insurance than these set forth or the shipper may expressly waive the requirements of any cargo insurance. Any such agreement or waiver shall be evidenced in writing and filed with the division in lieu of policy of insurance.

(B) 49 U.S.C. sections 14501(c) and 41713(b) generally preempts the states from enacting or enforcing any law, regulation, or other provision having the force and effect of law relating to the prices, routes and services of motor carriers of property (except household goods). The division interprets this federal law as generally preempting Missouri's uniform cargo liability rules, because the Act imposes a condition requiring those rules to be optional at the request of the carrier, which is not allowed by Missouri law. This section has therefore been amended to require cargo insurance only with respect to household goods.]

[(5)] **(A)** The certificate of **cargo liability** insurance shall state that the insurer has issued to the motor carrier **of household goods** a policy of insurance which by endorsement provides cargo insurance covering the obligations imposed upon the motor carrier by provisions of the law of this state. The certificate shall be on form H—Uniform Motor Carrier Cargo Certificate *[O]***o**f Insurance. The certificate shall be duly completed and executed by the insurer. **The endorsement shall be attached to the insurance policy and form a part of it. True copies of the policy with the endorsement attached shall be maintained at the motor carrier's principal place of business, and upon request shall be produced for inspection by the division within this state. The endorsement shall be on form I—Uniform Motor Carrier Cargo Insurance Endorsement, which shall be duly completed and executed by the insurer. The form I endorsement amends the insurance policy to which it is attached to assure compliance with this rule by the motor carrier.** The surety bond shall be in the form set forth in form J—Uniform Motor Carrier Cargo Surety Bond. The bond shall be duly completed and executed by the surety and principal. *[The division shall accept, as a fifteen (15)-day binder pending the receipt of the original form, legible copies of forms H and J filed with the division by fax transmission. If the original form is not received by the division within fifteen (15) days after receipt of the fax, then the carrier is not in compliance with this section and the division will accept only the original form.]*

(B) An insurance company or surety shall file separate certificates or bonds, whenever it provides both cargo liability and public liability coverage for a motor carrier of household goods.

(C) Any shipper and contract carrier of household goods may agree upon different limits of cargo insurance than this section requires, or the shipper may expressly waive cargo insurance coverage for all household goods shipments transported by the contract carrier. The agreement or waiver shall be evidenced in writing and filed with the division. When agreements or waivers are filed and in effect regarding all contracting shippers that a contract carrier may serve, upon the carrier's request, the division shall waive the filing of a cargo liability insurance certificate or surety bond for that carrier.

*[(6)]***(7) Cancellation and Reinstatement.** Except as provided in section *[(7)]***(8)** of this rule, an insurer under the provisions of this rule shall give the division not less than thirty (30) days' notice of the cancellation of motor carrier bodily injury and property damage liability insurance or motor carrier cargo insurance, by filing with the division the form of notice set forth in form K—Uniform Notice *[O]***o**f Cancellation *[O]***o**f Motor Carrier Insurance Policies. The notice shall be duly completed and executed by the insurer. A surety under the provisions of the rule shall give the division not less than thirty (30) days' notice of the cancellation of motor carrier bodily injury and property damage liability surety bond or motor carrier cargo surety bond, by filing with the division the form of notice set forth in form L—Uniform Notice *[O]***o**f Cancellation *[O]***o**f Motor Carrier Surety Bond. The notice shall be duly completed and executed by the surety or motor carrier. **After cancellation in accordance with this section, a new certificate of insurance or surety bond must be filed to reinstate coverage for the motor carrier. Except as otherwise required pursuant to SSRS, this section is applicable to interstate as well as intrastate motor carriers.**

[(7)] **(8) Replacement Coverage.** Policies of insurance and surety bonds required *[under]* **pursuant to** this rule may be replaced by other policies of insurance or surety bonds. The liability of the retiring insurer or surety shall be considered as having terminated on the effective date of the replacement policy of insurance or surety bond if accepted by the division; *[provided, however,]* **except** that if a cancellation notice under section *[(6)]***(7)** of this rule is received prior to receipt of the replacement certificate of insurance or surety bond, the liability of the retiring insurer or surety shall be considered as having terminated at the end of the thirty (30)-day cancellation period required in section *[(6)]***(7)** of this rule.

[(8) When the insurance company issuing the policy desires to write coverage on both public liability and property damage and cargo insurance, separate certificates and endorsements shall be used.]

(9) *[Before any policy of insurance shall be accepted by the division, the insurance company issuing the policy, or the carrier offering same,]* **Authorization of insurer or surety. Except as otherwise required pursuant to SSRS,** upon request of the division, **any insurance company that has filed or offers to file an insurance certificate** shall furnish evidence satisfactory to the division that the insurance company issuing the policy is duly authorized to transact business in Missouri and to issue the policy offered**,** and that it is financially able to meet its obligations.

(10) *[All insurance certificates and surety bonds filed with the division shall remain on file in the division and must not be removed from the division except with the written permission of the division.]* **Electronic Filing of Insurance Documents. Whenever the division determines that it has the capability, it may also accept insurance certificates, surety bonds, cancellations, or any other documents offered for filing pursuant to this rule, or section 390.126 or 390.128, RSMo, on behalf of intrastate or interstate motor carriers, or both, through any national clearinghouses or private databases, by electronic mail (E-mail), or by any other electronic media approved by the division.**

(A) Every motor carrier, insurance company, surety or other person that files a document electronically shall use the same document form as otherwise required by this rule, except that the division may accept for filing an electronic document containing only the particular information required of that motor carrier and insurance company, surety or other person, and the division shall incorporate by reference all other provisions of the required form. Whenever an electronic document is filed in this manner, all provisions of the required form shall be binding upon the motor carrier, insurance company, surety or other person identified in the document, to the same extent as if a fully executed paper document were filed.

(B) The division may require insurance or surety companies to use account numbers, passwords, and other forms of identification or authorization before filing a document electronically. Before the division accepts electronic documents for filing, each document shall be authenticated in a manner authorized by law and approved by the division. The division may require or accept electronic signatures, digital signatures, or other forms of authentication. The division will give public notice through the division's Internet web site, or other conspicuous manner, of the approved methods of offering and authenticating documents for filing electronically.

[(11) For reinstatement of insurance which has been cancelled, a new certificate of insurance must be filed.]

[(12) Forms E, F, G, H, I, J, K and L referred to in this rule are the standard forms determined by the National Association of Regulatory Utility Commissioners and adopted for use by this division. All insurance forms to be filed with the division, including duplicates and copies shall be legible. All insurance forms shall be filed in duplicate, including the original, signed form, on paper not greater in size than eight and one-half inches wide by five inches high (8 1/2" × 5"), except as follows:

(A) One (1) copy of a fifteen (15)-day binder may be filed by facsimile transmission as provided under section (3) or section (5) of this rule;

(B) One (1) copy of the proof of insurance required by the SSRS Procedures Manual may be filed with this division as provided under section (2), and may be filed on paper not greater in size than eight and one-half inches wide by eleven inches high (8 1/2" × 11"); and

(C) Bond form G may be filed on paper not greater in size than eight and one-half inches wide by eleven inches high (8 1/2"× 11").]

[(13) As used in this rule, unless the context clearly indicates otherwise, the following words and terms mean:

(A) Cancellation—the termination of insurance coverage by either the insurer or the insured;

(B) Endorsement—a written amendment to the insurance policy;

(C) Property damage—damage to or loss of use of tangible property; and

(D) Public liability—liability for injuries to the body, sickness or disease, including death resulting from any of these, and for property damage.]

AUTHORITY: sections ***390.041, 390.071, 390.126, 390.128,*** *622.027, RSMo [Supp. 1997] **2000**. Emergency rule filed June 14, 1985, effective July 1, 1985, expired Oct. 28, 1985. Original rule filed Aug. 1, 1985, effective Oct. 29, 1985. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 15, 2000, effective Jan. 2, 2001, expires June 30, 2001. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: It is estimated that this proposed amendment will not cost any state agency of the state government or any political subdivision thereof more than $500, in the aggregate, to any such agency or subdivision. The only such agency that the amendment directly affects is the Division of Motor Carrier and Railroad Safety. Pursuant to the Division's contract with National Online Registries (NOR), MCRS will incur no additional costs to implement this amendment by participating in and receiving electronically-filed insurance documents through NOR's on-line database system. MCRS, therefore, concludes that this amendment will not result in any net costs to the Division exceeding $500, in the aggregate.

PRIVATE COST: It is estimated that this proposed amendment will not cost private entities more than $500, in the aggregate, to any such entity. Potentially this amendment could affect the 9,785 motor carriers currently authorized by MCRS to transport passengers or property in Missouri intrastate or interstate commerce, as well as additional motor carriers who might apply for such operating authority in the future, and the insurance companies providing public liability or household goods cargo liability insurance coverage (or both) for authorized motor carriers. But MCRS concludes, based on communications with representatives of *both National Online Registries (NOR), the contractor through which MCRS will receive electronic insurance filings on behalf of motor carriers, and several insurance companies, that insurers generally will not charge motor carriers any additional fees or other charges to file the required insurance documents electronically, rather than by paper filings as provided by the current rule. Although NOR will initially charge insurance companies a fee of $2.50 per filing when they file insurance documents electronically, the amended rule does not require any motor carrier or insurance company to file the required documents electronically, but merely offers them the additional option of electronic filing. In addition, both NOR and insurance company officials have informed MCRS that the benefits gained by insurers who do elect to file electronically will ultimately result in net cost savings to the insurance companies that file electronically with MCRS, over and above the $2.50 fee for each document filed electronically. These benefits are expected*

to include insurers' on-line access to MCRS motor carrier database information, faster response to their insured clients, faster filing of insurance documents, fewer mistakes in documents filed, faster correction of mistakes that do occur, better customer service to the motor carriers, and elimination of mailing costs such as postage, envelopes, and photocopying. These benefits will improve customer service by the insurance companies to their insured motor carriers, at lower overall cost, and will enable motor carriers to comply with MCRS requirements more quickly, thus enabling motor carriers to start or resume lawful motor vehicle operations faster than without electronic insurance filing. MCRS, therefore, concludes that this amendment will not result in any net costs to the affected motor carriers or insurance companies of more than $500, in the aggregate, to any such entity.

NOTICE TO SUBMIT COMMENTS: Anyone may file with the division a written statement in support of or in opposition to this proposed amendment, to the attention of David E. Woodside, General Counsel, Missouri Division of Motor Carrier and Railroad Safety, P.O. Box 1216, Jefferson City, MO 65102-1216, fax (573) 526-3651, E-mail dwoodsid@mail.state.mo.us. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****, that is, no later than 5:00 p.m. on February 15, 2001. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 60—Vocational and Adult Education
Chapter 120—Vocational Education

PROPOSED RULE

5 CSR 60-120.080 Student Suicide Prevention Programs

PURPOSE: This rule establishes procedures for the establishment or expansion of student suicide prevention programs.

(1) The Department of Elementary and Secondary Education (DESE) will authorize a four (4)-year competitive grant program to Missouri public school districts to fund or defray the cost of establishment or expansion of student suicide prevention programs based upon legislative appropriation.

(2) Grant applications shall be made available annually by contacting the Guidance and Placement Services Section, DESE, P.O. Box 480, Jefferson City, MO 65102-0480. Applications shall include, but may not be limited to:

(A) Grantee's name, title and contact information;

(B) Description of any current or proposed student suicide prevention program:

1. If a student suicide prevention program exists, demonstrate a need for an improved program; and

2. An explanation of how the grant funds will implement or improve the program;

(C) Statements of assurance that the grantee will:

1. Comply with all reporting requirements of DESE relating to this grant award program; and

2. Recipients of grants must expend funds during the period which begins on the date DESE approves a proposal and ends the following June 30;

(D) A four (4)-year plan of implementation which addresses each of the program requirements, including:

1. A listing of major goals; and

2. A listing of procedures demonstrating the way the goals of the suicide prevention program will be executed including activities and time lines for each goal;

(E) A detailed line item budget of grant fund expenditures for year one (1) and anticipated expenditures for years two (2), three (3), and four (4); and

(F) A comprehensive plan to annually evaluate the effectiveness of the student suicide prevention program.

(3) The program grants that demonstrate the following will be given preference for approval:

(A) Activities designed to include teacher, counselor and administrator training in student suicide prevention programs;

(B) Implementation of skills based instruction targeting students at-risk;

(C) Activities to reinforce classroom instruction such as:

1. Development of public information messages;
2. Service learning;
3. Student-parent activities; and/or
4. Peer education activities; and/or

(D) Programs that include a parental involvement component.

(4) Grant funding will be awarded on a competitive basis and may be limited by availability of grant funds:

(A) Grants will be distributed in equal amounts within geographic areas established by DESE, proportionately based on student population. DESE may reallocate funds if an area has insufficient applications or insufficient eligible applications to obligate all funds for the area.

(5) The school district will keep records according to generally accepted accounting principles, and will provide any information necessary for fiscal and program auditing. All such records and supporting documents will be retained in accordance with current federal and state laws and regulations.

(6) Allowable expenditures for grants may only be used to pay for:

(A) Salaries and benefits;

(B) Materials and supplies;

(C) Equipment;

(D) Professional development; and/or

(E) Administration costs of awarded funds which do not exceed five percent (5%) of the grant.

(7) Grantees shall submit a mid-year report and a year-end report of every grant funded yearly. Continued funding will be contingent upon the accurate reports that are approved by DESE. These reports must contain, but are not limited to:

(A) A measure of progress demonstrating the recipients compliance with stated outcomes in the application;

(B) A detailed line item budget of expenditures;

(C) The number of students served by grant funds; and

(D) The number of teachers, counselors, and administrators provided training.

(8) Grants may be eligible for renewal for an additional four (4)-year period, based in part on results of the first four (4)-year grant.

(9) Grant applications from nonschool districts must provide a document of cooperation, approved by DESE, that assures cooperation between grantee and the sponsoring school district.

AUTHORITY: section 161.235, RSMo 2000. Original rule filed Dec. 7, 2000.

PUBLIC COST: This proposed rule is estimated to cost the Department of Elementary and Secondary Education $2,000,000 in Fiscal Year 2002 (subject to legislative appropriation), with the cost reoccurring annually thereafter over the life of the rule. A fiscal note containing a detailed estimated cost of compliance has been filed with the secretary of state.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or opposition to this proposed rule with the Missouri Department of Elementary and Secondary Education, Attention Dr. Nancy Headrick, Assistant Commissioner, Division of Vocational and Adult Education, P.O. Box 480, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COSTS

I. RULE NUMBER

Title:	5 – Department of Elementary and Secondary Education
Division:	60 – Division of Vocational and Adult Education
Chapter:	120 – Vocational Education
Type of Rulemaking:	Proposed Rule
Rule Number and Name:	5 CSR 60-120.080 Student Suicide Prevention Programs

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Elementary and Secondary Education	$2,000,000 per year for the life of the rule

III. WORKSHEET

These funds will provide for at least twenty (20) competitive grants not to exceed $100,000 per grant award. Each grant is for a four (4)-year period, but only renewable annually based upon approval of an annual report verifying that the program is meeting the stated goals and objectives and is in compliance with state law and department regulations. Grant funds can only be used to establish or expand a student suicide prevention program that is operated in a school. Therefore, the estimated cost is $2,000,000 per year.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 90—Vocational Rehabilitation
Chapter 4—General Administrative Policies

PROPOSED AMENDMENT

5 CSR 90-4.120 Minimum Standards for Service Providers. The board is proposing to amend subsection (1)(B).

PURPOSE: This amendment corrects a reference to an amended administrative rule.

(1) A service provider is an individual or organization which provides services to applicants or eligible individuals.

(B) An educational service provider must comply with the provisions found in *[5 CSR 30-4.020]* **5 CSR 60-900.050**.

AUTHORITY: sections 161.092, 178.600, 178.610, 178.620, RSMo [1994] 2000. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Amended: Filed Dec. 7, 2000.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Elementary and Secondary Education, Attention: Mr. Ronald W. Vessell, Assistant Commissioner, Division of Vocational Rehabilitation, 3024 Dupont Circle, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 90—Vocational Rehabilitation
Chapter 5—Vocational Rehabilitation Services

PROPOSED AMENDMENT

5 CSR 90-5.400 Services. The State Board of Education is amending the rule by adding paragraph (1)(A)3.

PURPOSE: This amendment expands the number of eligible individuals with disabilities who may receive tuition or required fees towards training.

(1) Vocational rehabilitation services as defined in the federal act and/or applicable regulations may be provided to individuals.

(A) Financial Need.

1. The following vocational rehabilitation services as defined in the federal act and/or applicable regulations may be provided to individuals based upon financial need:

A. Physical and/or mental restoration, including but not limited to hospitalization, medical treatment, surgery, dentistry, and prosthesis;

B. Training, including tuition, fees, books, supplies, training materials and other services associated with training;

C. Maintenance;

D. Transportation;

E. Placement tools, including initial stock and supplies associated with placement;

F. Rehabilitation technology service, including assistive technology devices and services to assist the individual to achieve an employment outcome;

G. Home modification or remodeling;

H. Vehicle modification;

I. Services to family members to assist the individual to achieve an employment outcome;

J. Personal attendant services;

K. Note-taking services, not involving sign language interpretation; and/or

L. Other goods and services not listed above to assist the individual to achieve an employment outcome.

2. Financial need is based upon the individual's adjusted gross income level of the most recent tax records less unreimbursed disability related expenses as approved by the Division of Vocational Rehabilitation (DVR) and compared to one hundred eighty-five percent (185%) of the U.S. Department of Health and Human Services poverty level for Missouri and the Consumer Price Index as updated on an annual basis.

3. Individuals who are below three hundred percent (300%) of the U.S. Department of Health and Human Services poverty level for Missouri and the Consumer Price Index as updated on an annual basis, and do not receive any services based upon financial need as listed in this subsection, may receive an annual fixed amount as determined by DVR, to be applied toward tuition costs or required fees for training services. This amount may be authorized by DVR for a twelve (12) month period of time on an annual basis, beginning on the date of services listed on the Individualized Plan for Employment (IPE).

AUTHORITY: sections 161.092, 178.600, 178.610 and 178.620, RSMo [1994] 2000. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Amended: Filed Dec. 7, 2000.

PUBLIC COST: This proposed amendment is estimated to cost the Missouri Department of Elementary and Secondary Education $127,800 in Fiscal Year 2002, with the cost reoccurring annually thereafter over the life of the rule. A fiscal note containing a detailed estimated cost of compliance has been filed with the Secretary of State.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Elementary and Secondary Education, Attention: Mr. Ronald W. Vessell, Assistant Commissioner, Division of Vocational Rehabilitation, 3024 Dupont Circle, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 5 - Department of Elementary and Secondary Education

Division: 90 – Vocational Rehabilitation

Chapter: 5 – Vocational Rehabilitation Services

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 5 CSR 90-5.400 Services

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Dept. of Elementary and Secondary Education	$127,800 per year for the life of the rule

III. WORKSHEET

For this amendment, an estimated 1,200 more individuals will be provided tuition and required fees at an average of $500 per person per fiscal year. The cost of this will be $600,000 per fiscal year. The state portion is figured by multiplying 21.3% times $600,000. Therefore, the estimated cost is $127,800 per year.

IV. ASSUMPTIONS

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 90—Vocational Rehabilitation
Chapter 5—Vocational Rehabilitation Services

PROPOSED AMENDMENT

5 CSR 90-5.440 Training. The State Board of Education is proposing to amend sections (1), (2) and paragraph (1)(A)2.

PURPOSE: This amendment corrects a reference to an amended administrative rule.

(1) The following training services as defined in the federal act and/or applicable regulations, and *[5 CSR 30-4.020]* **5 CSR 60-900.050** may be provided to eligible individuals based upon financial need:

(A) College, vocational, or proprietary training at an accredited institution may be provided to assist eligible individuals in reaching objectives that are within the scope of their functional limitations, interests, aptitudes and abilities.

1. Eligible individuals must be enrolled in and satisfactorily complete courses that constitute a normal course load for full-time students unless circumstances as approved by the Division of Vocational Rehabilitation (DVR), indicate a need for a reduced course load.

2. Colleges, universities, vocational or proprietary schools must comply with the provisions found in *[5 CSR 30-4.020]* **5 CSR 60-900.050**.

3. For eligible individuals enrolled in private or proprietary degree colleges in Missouri, the cost of the education is based upon the nearest Missouri tax supported two (2) or four (4) year college appropriate for the eligible individual to reach their vocational objective. This includes all primary rehabilitation services (e.g. tuition and fees) and secondary rehabilitation services (e.g. maintenance, transportation, books and supplies) which are determined to be necessary for the eligible individual to attend college. The following are exceptions:

A. The specific job objective which the individual is seeking is not available at the nearest Missouri tax supported two (2) or four (4) year college; and/or

B. The nearest Missouri tax supported two (2) or four (4) year college does not provide appropriate services for the individual's disability-related needs.

4. Division of Vocational Rehabilitation's maximum rate of authorization for out-of-state college tuition is based upon the lesser of the hourly rate at the University of Missouri-Columbia (updated annually) or the hourly rate of the particular out-of-state college. This amount may be applied to any of the eligible individual's educational cost(s). For out-of-state colleges any grants, aid, loans, and/or work-study awarded will be used to reduce the individual's participation in the educational costs.

5. Any change in vocational goals involving college, vocational, or proprietary training must be agreed to and signed by the individual and approved by DVR.

6. The eligible individual is responsible for the cost of the tuition and/or required textbooks when courses are dropped, withdrawn and/or retaken due to poor grades, unless the eligible individual's reason for withdrawing, dropping and/or failing a course is disability-related or a credit or refund has been obtained.

7. The individual and/or parents must complete DVR's Financial Application. The individual and/or parents must apply for all applicable federal grants and campus financial aid. If an individual is awarded any grant(s) and attends an in-state college, the grant(s) will be used to reduce DVR's participation in the educational costs.

A. If an individual attends a Missouri public, private or proprietary degree program, all federal grants and aid must be used to reduce agency participation in the educational costs.

B. If the individual participates in a work-study program or obtains student loans, money received from either may be used for educational costs not covered by DVR.

C. If an individual attends an out-of-state college or university, all federal grants and aid may be used to pay for educational costs which exceed DVR's level of funding.

8. The eligible individual is responsible for the cost of tuition, books and supplies for elective courses that do not apply to the eligible individual's degree or program.

9. The eligible individual must acquire and maintain at least a minimum grade point average of 2.0 (based on a four (4) point scale) or a 3.0 (based on a five (5) point scale).

10. The eligible individual shall provide a grade report after each semester, quarter, trimester, etc., that documents hours taken, hours completed, grades for each course and grade point average;

(2) The following training services as defined in the federal act and/or applicable regulations, and *[5 CSR 30-4.020]* **5 CSR 60-900.050** may be provided to eligible individuals regardless of financial need:

*AUTHORITY: sections 161.092, 178.600, 178.610 and 178.620, RSMo [1994] **2000**. Original rule filed Dec. 17, 1999, effective Aug. 30, 2000. Amended: Filed Dec. 7, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Elementary and Secondary Education, Attention: Mr. Ronald W. Vessell, Assistant Commissioner, Division of Vocational Rehabilitation, 3024 Dupont Circle, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 15—Division of Aging
Chapter 15—Residential Care Facilities I and II

PROPOSED RULE

13 CSR 15-15.045 Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia

PURPOSE: This rule establishes the additional standards for those residential care facilities II which admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

EDITOR'S NOTE: All rules relating to long-term care facilities licensed by the Division of Aging are followed by a Roman Numeral notation which refers to the class (either Class I, II or III) of standard as designated in section 198.085.1, RSMo.

(1) Definitions. For the purposes of this rule, the following definitions shall apply:

(A) Activities of daily living (ADLs) mean a resident's ability to eat, bathe, toilet, dress, transfer and ambulate.

(B) Chemical restraint means a psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.

(C) Convenience means any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interests.

(D) Discipline means any action taken by the facility for the purpose of punishing or penalizing residents.

(E) Individual service plan means the planning document which outlines and describes the services to be provided and the outcomes expected in order to meet the resident's needs.

(F) Licensed professional means any of the following:

1. Physician, as defined in and licensed under the provisions of Chapter 334, RSMo;

2. Nurse, as defined in and licensed under the provisions of Chapter 335, RSMo;

3. Psychologist, as defined in and licensed under the provisions of Chapter 337, RSMo;

4. Professional counselor, as defined in and licensed under the provisions of Chapter 337, RSMo; and

5. Clinical social worker, as defined in and licensed under the provisions of Chapter 337, RSMo.

(G) Physical restraint means any physically applied method, or mechanical device which the resident cannot easily remove, that restricts the free movement or normal functioning of any portion of the resident's body, or the resident's normal access to common areas and his or her personal spaces.

(H) Resident, only for the purpose of this rule, means an individual who is mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia, who is admitted to or continues to be cared for in the facility under the provisions of this rule.

(I) Significant change means any change in the resident's physical, emotional or psychosocial condition or behavior that would require an adjustment or modification in the resident's treatment or services.

(2) General Requirements.

(A) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not care for such residents unless:

1. The resident has been diagnosed with Alzheimer's disease or other dementia by a physician licensed to practice medicine; and

2. The facility is able to provide appropriate services for and meet the needs of the resident. I/II

(B) A residential care facility II may admit or continue to care for residents who have been diagnosed with Alzheimer's disease or other dementia if the residents are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, providing the facility is in substantial compliance with the provisions of Chapter 198, RSMo and all regulations under which the facility is licensed by the Division of Aging. I/II

(C) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall comply with the provisions of the Alzheimer's Special Care Disclosure Act pursuant to sections 198.500 to 198.515, RSMo. The facility shall complete, and submit to the Division of Aging, an Alzheimer's Special Care Services Disclosure form (MO Form 886-3548), which is incorporated by reference in this rule. II

(D) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not admit, retain or continue to care for any resident who is mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids who:

1. Has exhibited behaviors which indicate that the resident is a danger to self or others;

2. Is at constant risk of elopement and, despite repeated interventions which have not altered the resident's behavior, continues to be a danger to self;

3. Requires physical or chemical restraint as defined in this rule;

4. Requires skilled nursing services as defined in section 198.006(17), RSMo for which the facility is not licensed or able to provide;

5. Requires more than one person to simultaneously provide physical assistance to the resident with any activity of daily living, with the exception of bathing; or

6. Is bed-bound or chair-bound and is unable to ambulate due to a debilitating or chronic condition. I/II

(3) Physical Design and Fire Safety Requirements.

(A) The facility shall be equipped with a complete sprinkler system installed and maintained in accordance with the 1996 edition of the National Fire Protection Association (NFPA) 13, *Standard for the Installation of Sprinkler Systems*, or the 1996 edition of NFPA 13R, *Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height,* which are incorporated by reference in this rule. I/II

(B) The facility shall be equipped with a complete electrically supervised fire alarm system in accordance with the provisions of the 1997 *Life Safety Code for Existing Health Care Occupancy*, incorporated by reference in this rule. The system shall include smoke detectors located no more than thirty feet (30') apart in corridors with no point in the corridor located more than fifteen feet (15') from a smoke detector. The fire alarm system shall be equipped to automatically transmit an alarm to the fire department. I/II

(C) Each floor used for resident bedrooms shall be divided into at least two (2) smoke sections by one (1)-hour rated smoke stop partitions. No smoke section shall exceed one hundred fifty feet (150') in length. If, however, neither the length nor width of a floor exceeds seventy-five feet (75'), no smoke stop partitions are required. Openings in smoke stop partitions shall be protected by one and three-fourths inches (1 3/4")-thick solid core wood doors or metal doors with an equivalent fire rating. The doors shall be equipped with closers and magnetic hold-open devices. Any duct passing through this smoke wall shall be equipped with automatic resetting smoke dampers that are activated by the fire alarm system. Smoke partitions shall extend from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. II

(D) In a multilevel facility, residents who are mentally incapable of negotiating a pathway to safety shall be housed only on a ground floor. The ground floor shall be any floor that has at least one exit at grade. All other required exits shall be at grade, or with no more than two steps to grade, or with a ramp to grade. The ramp shall have a maximum slope of one to twelve (1:12) leading to grade. II

(E) When a resident resides among the entire general population of the facility, the facility shall take necessary measures to provide such residents with the opportunity to explore the facility and, if appropriate, its grounds. When a resident resides within a designated, separated area that is secured by limited access, the facility shall take necessary measures to provide such residents with the opportunity to explore the separated area and, if appropriate, its grounds. If enclosed or fenced courtyards are provided, residents shall have reasonable access to such courtyards. Enclosed or fenced courtyards that are accessible through a required exit door shall be large enough to provide an area of refuge for fire safety at least thirty feet (30') from the building. Enclosed or fenced courtyards that are accessible through a door other than a required exit shall have no size requirements. II

(F) The facility shall provide freedom of movement for the residents to common areas and to their personal spaces. The facility shall not lock residents out of or inside their rooms. Key operated locks shall not be permitted on resident room doors. I/II

(G) Every facility shall use a personal electronic monitoring device for any resident whose physician recommends the use of such device. II

(H) The facility may provide a designated, separated area where residents, who are mentally incapable of negotiating a pathway to safety, reside and receive services and which is secured by limited access if the following conditions are met:

1. Dining rooms, living rooms, activity rooms, and other such common areas shall be provided within the designated, separated area. The total area for common areas within the designated, separated area shall be equal to at least forty (40) square feet per resident; II/III

2. Doors separating the designated, separated area from the remainder of the facility or building shall not be equipped with locks that require a key to open; I/II

3. If locking devices are used on exit doors egressing the facility or on doors accessing the designated, separated area, delayed egress magnetic locks shall be used. These delayed egress devices shall comply with the following:

A. The lock must unlock when the fire alarm is activated;

B. The lock must unlock when the power fails;

C. The lock must unlock within thirty (30) seconds after the release device has been pushed for at least three (3) seconds, and an alarm must sound adjacent to the door;

D. The lock must be manually reset and cannot automatically reset; and

E. A sign shall be posted on the door that reads: PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS. I/II

4. The delayed egress magnetic locks may also be released by a key pad located adjacent to the door for routine use by staff. I/II

(4) Staffing Requirements.

(A) The facility shall be staffed twenty-four (24) hours a day by the adequate number and type of personnel necessary for the proper care of residents and upkeep of the facility in accordance with the staffing requirements found in 13 CSR 15-15.042. In meeting such staffing requirements, every resident who is mentally incapable of negotiating a pathway to safety shall count as three (3) residents. I/II

(B) All on-duty staff of the facility shall, at all times, be awake, dressed in on-duty work attire, and prepared to assist residents in case of emergency. I/II

(5) Assessments and Individual Service Plans.

(A) Prior to admitting or continuing to care for a resident diagnosed with Alzheimer's disease or other dementia, a family member or legal representative of the resident, in consultation with the resident's primary physician, shall meet with a facility representative to determine if the facility can meet the needs of the resident. The facility shall document the decisions regarding admission or continued placement in the facility through written verification by the family member, physician and the facility representative. II

(B) After consultation, if the facility admits or continues to care for the resident, a Minimum Data Set (MDS) assessment shall be completed on an MDS form provided by the Division of Aging to assess the needs of each resident who is mentally incapable of negotiating a pathway to safety. II/III

(C) Each resident shall be assessed by a licensed professional, as defined in subsection (1)(F) of this rule, by use of the MDS:

1. Within ten (10) days of admission; and

2. Every one hundred eighty (180) days thereafter; or

3. Whenever a significant change occurs in the resident's condition as defined in subsection (1)(I) of this rule. I/II

(D) Based on the MDS assessment, an interdisciplinary team shall develop an individual service plan for each resident who is mentally incapable of negotiating a pathway to safety. Whenever possible and appropriate, the resident, family members or other individuals instrumental in identifying the needs of, or providing treatment or services to, the resident shall be involved in the development or revision of the individual service plan. Every individual service plan shall be signed by each person participating in its development. II/III

(E) An individual service plan shall be completed and implemented within twenty (20) days after the completion of an MDS assessment of a resident. I/II

(F) An individual service plan shall describe the resident's needs and preferences, the specific methods and services to meet those needs, desired outcomes or interventions, and the names of the staff, service provider, and if applicable, family members who are primarily responsible for implementing the individual service plan. At a minimum, the individual service plan for each resident shall identify:

1. The resident's capabilities, strengths, potential, preferences and customary behaviors;

2. The resident's behavioral, medical and social needs based on the assessment;

3. The services provided to meet the needs of the resident;

4. The expected outcomes of the services provided; and

5. Staff or other persons responsible for providing the services to meet the needs of the resident. II/III

(G) The facility shall make each resident's individual service plan available for use to all persons providing services to that resident. II/III

(6) Staff Training and Orientation.

(A) All facility personnel who provide direct care to residents who are mentally incapable of negotiating a pathway to safety shall receive at least twenty-four (24) hours of training within the first thirty (30) days of employment.

1. At least twelve (12) hours of the twenty-four (24) hours of training shall be classroom instructions; and

2. Six (6) classroom instruction hours and two (2) on-the-job training hours shall be related to the special needs, care and safety of residents with dementia. II

(B) If residents who are mentally incapable of negotiating a pathway to safety reside among the entire general population of the facility, all facility personnel, regardless of whether such personnel provide direct care to residents who cannot negotiate a pathway to safety, shall receive on a quarterly basis at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. If residents who are mentally incapable of negotiating a pathway to safety reside within a designated, separated area that is secured by limited access, all personnel who have or could have contact with residents residing in the designated, separated area which is secured by limited access, shall receive on a quarterly basis at least four (4) hours of in-service

training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. II

(C) Any training related to the special needs, treatment and safety of residents with dementia shall include, but not be limited to, the following:

1. An overview of Alzheimer's disease and other dementia;

2. Communication techniques which are effective in enhancing and maintaining communication skills for residents with dementia;

3. Components of or techniques for creating a safe, secure and socially oriented environment for residents with dementia;

4. Provision of structure, stability and a sense of routine for residents based on their needs;

5. Effective management of different or difficult behaviors; and

6. Issues involving families and care givers. II/III

(D) The initial twenty-four (24) hours of training required within the first thirty (30) days of employment shall include, at a minimum, all of the components in subsection (6)(C) of this rule. II

(E) The in-service training to be provided on a quarterly basis shall include at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. Each component listed in subsection (6)(C) of this rule must be included over the course of each twelve (12)-month period. II

(F) All in-service or orientation training relating to the special needs, care and safety of residents who are mentally incapable of negotiating a pathway to safety shall be conducted, presented or provided by a training instructor who is qualified by education, experience or knowledge in the care of individuals with Alzheimer's disease or other dementia. II/III

(7) Programs and Services for Residents Who are Mentally Incapable of Negotiating a Pathway to Safety.

(A) Each facility shall make available and implement self-care, productive and leisure activity programs for persons with dementia which maximize and encourage the resident's optimal functional ability. The facility shall provide activities that are appropriate to the resident's individual needs, preferences, background and culture. Individual or group activity programs may consist of the following:

1. Gross motor activities, such as exercise, dancing, gardening, cooking and chores;

2. Self-care activities, such as dressing, grooming and personal hygiene;

3. Social and leisure activities, such as games, music and reminiscing;

4. Sensory enhancement activities, such as auditory, olfactory, visual and tactile stimulation;

5. Outdoor activities, such as walking and field trips;

6. Creative arts; or

7. Other social, leisure or therapeutic activities that encourage mental and physical stimulation or enhance the resident's well-being. II/III

(B) The facility shall develop and implement written policies and procedures which address, at a minimum:

1. The facility's admission, transfer and discharge criteria taking into account the individual's needs and the facility's ability to meet those needs;

2. The basic services provided or offered to residents with Alzheimer's disease or other dementia;

3. The procedures and actions to be taken in the event of resident elopement;

4. The development and implementation of individual service plans;

5. The assignment of staff to residents based on the resident's needs which minimize resident confusion and maintain familiarity with environment;

6. Staff orientation and in-service training relating to the special needs, care and safety of residents with dementia;

7. Fire drill and emergency evacuation procedures for residents who are mentally incapable of negotiating a pathway to safety; and

8. The protection of the rights, privacy and safety of residents and the prevention of financial exploitation of residents. II/III

AUTHORITY: section 198.073, RSMo 2000. Emergency rule filed Dec. 14, 2000, effective Jan. 2, 2001, expires June 30, 2001. Original rule filed Dec. 14, 2000.

PUBLIC COST: This proposed rule will cost participating county/nursing home district residential care facilities II $12,012 in FY-02, and $5,208 in FY-03 and annually thereafter for the life of the rule. A detailed fiscal note containing the estimated cost of compliance has been filed with the secretary of state.

PRIVATE COST: This proposed rule will cost participating private entities $98,208 in FY-02, $249,942 in FY-03, $446,490 in FY-04, and $290,400 annually thereafter for the life of the rule. This proposed rule will cost participating private entities with Safe Units $768,350 in FY-02, and $124,080 thereafter for the life of the rule. The annual impact will include some costs to small businesses. A detailed fiscal note containing the estimated cost of compliance has been filed with the secretary of state.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Richard C. Dunn, Director, Division of Aging, 615 Howerton Court, P.O. Box 1337, Jefferson City, MO 65102-1337. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 13 - Department of Social Services

Division: 15 - Division of Aging

Chapter: 15 - Residential Care Facilities I and II

Type of Rulemaking: Proposed Rule

Rule Number and Name: 13 CSR 15-15.045—Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2	County/Nursing Home District Residential Care Facilities II	FY-02 - $12,012
2	County/Nursing Home District Residential Care Facilities II	FY-03 - $5,208*

*Annually for the life of the rule

III. WORKSHEET

- Staff Training: Eleven (11) full-time employees of one (1) LPN @ $11/hr., four (4) Med. Aides @ $6.25/hr., three (3) CNAs @ $10/hr., three (3) non-direct care staff @ $5.35/hr., and five (5) part-time employees of one (1) RN @ $18/hr., three (3) Med. Aides @ $6.25/hr., and one (1) CNA @ $10/hr. Total direct care wages/hr. = $112.75; total staff wages/hr. = $129.00/hr. Twenty percent (20%) staff turnover rate @ avg hr rate = Three (3) staff @ $8/hr.= $24/hr.
  24 hrs. Orientation x $112.75 = $2,706 (first year only); 24 hrs. Orientation x $24 = $576 (ongoing); 16 hrs. In-service training x $129/hr. = $2,064. Total training costs/RCF II for first year: $2,706 + $576 + $2,064 = $5,346. Ongoing training costs/RCF II: $576 + $2,064 = $2,640.

- Fire Safety Requirements: One and three-fourths inches solid core doors @ $300/door. Non-locking door knobs @ $20/resident room door. Average cost per affected RCF II = $660

IV. ASSUMPTIONS

1. All rules in 13 CSR 15 are integrally related. All Chapter 15 rules should be considered collectively to obtain a complete assessment of the costs related to Residential Care Facilities (RCFs).

2. There are 14 Nursing Home Districts with approximately 30 RCF IIs. For the purposes of completing this fiscal note, it is assumed that the average RCF II has 27 residents with 11 full-time staff and 5 part-time staff. Three of the 11 staff do not provide direct care. The turnover rate among staff is assumed to be 20%.

3. Assumes that all employees, both full-time and part-time, attend required orientation and training.

4. In the first year (FY-02) it is assumed that two RCF IIs shall decide to admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids due to Alzheimer's disease or other dementia. It is assumed that this number will remain constant for the life of the rule, as this rule does not require RCFs to participate.

5. Assumes that each participating RCF II will have three (3) residents with Alzheimer's disease or other dementia who cannot mentally negotiate a pathway to safety.

6. Assumes that both of the participating facilities will need to meet the additional fire safety standards. In FY-02 it will cost the (2) RCF IIs $1,320 for doors and hardware.

7. This rule is mandated by section 198.073, RSMo (Supp. 1999); therefore, the life of the rule cannot be determined by the Division of Aging.

8. As this rule is substantially based on the statutory requirements of Chapter 198, RSMo (Supp. 1999), a takings analysis is not required under section 536.017, RSMo (Supp. 1999). However, a takings analysis has occurred and a determination made that the proposed rule does not constitute a taking of real property under relevant state and federal laws.

9. Any other costs not identified within this fiscal note are unforeseen and unquantifiable.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 13 - Department of Social Services

Division: 15 - Division of Aging

Chapter: 15 - Residential Care Facilities I and II

Type of Rulemaking: Proposed Rule

Rule Number and Name: 13 CSR 15-15.045—Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
18	Residential Care Facilities II	FY-02 - $98,208
55	Residential Care Facilities II	FY-03 - $249,942
110	Residential Care Facilities II	FY-04 - $446,490
110	Residential Care Facilities II	FY-05 - $290,400*
55	RCF IIs with Safe Units	FY-03 - $768,350
55	RCF IIs with Safe Units	FY-04 - $124,080*

*Annually for the life of the rule

III. WORKSHEET

- Staff Training: Eleven (11) full-time employees of one (1) LPN @ $11/hr., four (4) Med. Aides @ $6.25/hr., three (3) CNAs @ $10/hr., three (3) non-direct care staff @ $5.35/hr., and five (5) part-time employees of one (1) RN @ $18/hr., three (3) Med. Aides @ $6.25/hr., and one (1) CNA @ $10/hr. Total direct care wages/hr. = $112.75; total staff wages/hr. = $129.00/hr. Twenty percent (20%) staff turnover rate @ avg hr rate = Three (3) staff @ $8/hr.= $24/hr.
  24 hrs. Orientation x $112.75 = $2,706 (first year only); 24 hrs. Orientation x $24 = $576 (ongoing); 16 hrs. In-service training x $129/hr. = $2,064. Total training costs/RCF II for first year: $2,706 + $576 + $2,064 = $5,346. Ongoing training costs/RCF II: $576 + $2,064 = $2,640.
- Staff Training for RCF II Safe Unit: For six (6) residents/Safe Unit - one (1) LPN; two (2) Med. Aides; two (2) CNAs; and three (3) part-time Med. Aides. Unit hourly wage = $62.25 x 24 hrs training = $1,494 (first year only); turnover rate of 20% = one x $8/hr x 24 hrs. = $192; in-service training for all staff = $2,064.
  FY-02: $1,494 + $192 + $2,064 = $3,750; FY-03: $192 + $2,064 = $2,256

- Fire Safety Requirements: One and three-fourths inches solid core doors @ $300/door. Non-locking door knobs @ $20/resident room door. Average cost per affected RCF II = $660
- For RCF II with Safe Unit - Delayed egress locking systems @ $2,000/door; Additional square feet (15 ft @ $82/sq ft = $1,230/resident x 6 residents = $7,380
  FY-02 cost for six (6) resident Safe Unit = $3,750 (training) + $600 (doors) + $240 (door knobs) + $2,000 (delayed egress door) + $7,380 = $13,970/RCF II x 55 RCF II = $768,350 FY-03 cost for ongoing and in-service training = $2,256/RCF II x 55 RCF II = $124,080

IV. ASSUMPTIONS

1. All rules in 13 CSR 15 are integrally related. All Chapter 15 rules should be considered collectively to obtain a complete assessment of the costs related to Residential Care Facilities (RCFs).

2. There are 356 RCF IIs with 15,556 beds and 9,966 residents. The occupancy rate is 56%. For the purposes of completing this fiscal note, it is assumed that the average RCF II has 27 residents with 11 full-time staff and 5 part-time staff. Three of the 11 staff do not provide direct care. The turnover rate among staff is assumed to be 20%.

3. Assumes that all employees, both full-time and part-time, attend required orientation and training.

4. In the first year (FY-01) it is assumed that five percent (5%) of the RCF IIs (18 RCF IIs) shall decide to admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids due to Alzheimer's disease or other dementia. In FY-03 the number of RCF IIs will increase by 37 facilities to 55 facilities (15%). In FY-04 the number of RCF IIs will increase by 55 facilities to 110 facilities (30%). It is assumed that the 30% rate will remain constant for the life of the rule, as this rule does not require RCFs to participate.

5. Assumes that each participating RCF II will have three (3) residents with Alzheimer's disease or other dementia who cannot mentally negotiate a pathway to safety.

6. Assumes that twenty percent (20%) of participating facilities will need to meet the additional fire safety standards. In FY-02 it will cost three (3) RCF IIs $1,980 for doors and hardware; in FY-03 it will cost seven (7) RCF IIs $4,620 in doors and hardware; and in FY-04 it will cost eleven (11) RCF IIs $7,260 for doors and hardware.

7. This rule is mandated by section 198.073, RSMo (Supp. 1999); therefore, the life of the rule cannot be determined by the Division of Aging.

8. As this rule is substantially based on the statutory requirements of Chapter 198, RSMo (Supp. 1999), a takings analysis is not required under section 536.017, RSMo (Supp. 1999). However, a takings analysis has occurred and a determination made that the proposed rule does not constitute a taking of real property under relevant state and federal laws.

9. Any other costs not identified within this fiscal note are unforeseen and unquantifiable.

Missouri Department of Social Services/Division of Aging
Missouri Department of Health/Division of Health Standards and Licensure
Alzheimer's Special Care Services Disclosure

PURPOSE

Long-term care facilities which provide or offer to provide care for persons with Alzheimer's disease by means of a special care unit or program are mandated by section 198.510. RSMo, to disclose information to the Division of Aging about those elements of their program which distinguishes the unit or program as being especially suitable for persons with Alzheimer's or other dementias. This disclosure form, along with a document or brochure containing information on selecting an Alzheimer's special care program, must be submitted to the Division of Aging as part of the licensure application. Facilities are also required to disclose the same information to residents, their next of kin, designee or guardian at the time of admission.

IDENTIFYING INFORMATION (PLEASE TYPE OR PRINT)

Facility Name

Address

Phone Type of License Unit Capacity

Person in Charge of Program Oversight

PROGRAM PHILOSOPHY

Briefly describe the philosophy of the Special Care Program.

ADMISSION & DISCHARGE INFORMATION

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

A. - Check the following admissions criteria and procedures that apply to the Special Care Program:

- ◯ Medical Confirmation of Alzheimer's or Related Dementia
- ◯ Pre-admission Family Interview
- ◯ Pre-admission Observation
- ◯ Tour of the Special Care Program, Explanation of Unique Features
- ◯ Additional Admission Criteria (include any other diagnostic or functional capacity requirements; ability to ambulate..etc.):

B. - Check the following discharge and/or transfer criteria and that apply to residents in the program:

- ◯ No Longer Ambulatory
- ◯ Specialized Nursing Procedures Required
- ◯ Unable to Feed Self
- ◯ Unable to Benefit from Therapuetic Programming
- ◯ Additional Criteria: _____

C. - Describe any specialized services available to assist with transfer and discharge planning for special program participants:

ASSESSMENT

A. - Describe how the process for evaluating Special Care Program participants and developing a plan of care may differ from procedures followed elsewhere in the facility.

B. - Explain how the facility ensures that staff carry out the plan of care for Special Care Program participants and how the plan of care changes in response to the participant's condition.

STAFF TRAINING

A. - Do staff who work with the Special Care Program receive specialized training not provided to staff in the rest of the facility? ◯YES ◯NO

B. - If so, indicate how many hours annually of specialized training by type of staff:

RNs & L.P.Ns: _____ Hours Per Year C.N.As: _____ Hours Per Year Support: _____ Hours Per Year Volunteers: _____ Hours Per Year

C. -List the topics of this specialized training provided to staff in the Special Care Unit:

_____

_____

_____

_____

PHYSICAL ENVIRONMENT & RESIDENT SAFTEY

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

Indicate any of the program's physical design & security features designed to safeguard individuals with Alzheimer's and dementia and enhance their lives:

◯ Door Alarms ◯ Wander Guard ◯ Enclosed Courtyard

◯ Door Locks ◯ Lockout Elevators

Other Features:

_____

_____

_____

_____

_____

RESIDENT ACTIVITIES

List the types and frequency of activities offered by the Special Care Program which are different than those offered in the rest of the facility:

_____

_____

_____

_____

_____

_____

FAMILY INVOLVEMENT

Items in the checklist below are characteristics of some Special Care Programs and do not necessarily represent regulatory requirements.

Indicate those features available to family members of residents in the program:

- ◯ Alzheimer's Family Support Group
- ◯ Respite Care
- ◯ Support Staff Assigned to Work with Family Members
- ◯ Educational Materials on Alzheimer's & Other Dementia's

Other Features:

_____

_____

_____

_____

PROGRAM COSTS

A. - How does the cost for participants in the Special Care Program differ from the cost for other residents in the facility?

_____

_____

_____

_____

_____

B. - If there is an additional cost for participants in the Special Care Program, what additional services are provided?

_____

_____

_____

_____

_____

C. - Please indicate any other optional services available only to Special Care Program participants at an additional cost:

_____

_____

_____

_____

D. - Does the facility have designated Medicaid beds available in the Special Care Program? ◯ YES ◯ NO

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 31—Child Abuse

PROPOSED RESCISSION

13 CSR 40-31.050 Child Fatality Review Process. This rule applied to the State Technical Assistance Team and the Child Fatality Review Panels fulfilling their responsibility in identifying and preventing child fatalities in this state.

PURPOSE: This rule is proposed for rescission because the Division of Family Services is no longer responsible for overseeing the State Technical Assistance Team and the Child Fatality Review Process. The director of the Department of Social Services has transferred the State Technical Assistance Team to the Division of Legal Services along with responsibility for the child fatality review process. An emergency rule and accompanying proposed rule containing the revised procedures relating to this area appear in this edition of the ***Missouri Register****.*

AUTHORITY: section 207.020, RSMo 1986. Original rule filed June 15, 1989, effective Jan. 1, 1990.Emergency rescission and emergency rule filed Dec. 20, 1991, effective Jan. 1, 1992, expired April 29, 1992. Emergency rescission and emergency rule filed April 16, 1992, effective April 26, 1992, expired Aug. 23, 1992. Rescinded and readopted: Filed Jan. 3, 1992, effective Aug. 6, 1992. Emergency rescission filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Director, Division of Family Services, 615 Howerton Court, P.O. Box 88, Jefferson City, MO 65103-0088. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 32—Child Care

PROPOSED RULE

13 CSR 40-32.020 Processing of Applications for State and Federal Funds for Providing Child Care Services

PURPOSE: The purpose of this rule is to implement the provisions of section 210.025, RSMo 2000 relating to conducting background checks of persons applying for state or federal funds for providing child care services in the home.

(1) General. To qualify for receipt of state or federal funds for providing child care services in the home either by direct payment or through reimbursement to a child care beneficiary, an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, and any person over the age of eighteen (18) who is living in the applicant's home shall be required to submit to background checks as prescribed below. A person over the age of eighteen (18) is a person who has attained his or her eighteenth birthday. These required background checks include the following:

(A) A criminal background check pursuant to section 43.540, RSMo;

(B) A check of the child abuse central registry established pursuant to section 210.145, RSMo; and

(C) A check of licensure suspensions and revocations pursuant to section 210.221 or 210.496, RSMo.

(2) Processing of Applications.

(A) Upon receipt of an application for state or federal funds for providing child care services in the home, pursuant to section 210.025, RSMo, or upon review of a recipient, pursuant to 210.027, RSMo, which review shall occur at least annually, the Division of Family Services shall:

1. Determine if a probable cause (or reason to suspect) finding of child abuse or neglect involving the applicant, pursuant to section 210.025, RSMo, or the recipient, pursuant to section 210.027, RSMo, or any person over the age of eighteen (18) who is living in the applicant's home has been recorded pursuant to section 210.221 or 210.145, RSMo;

2. Determine if the applicant, pursuant to section 210.025, RSMo, or the recipient, pursuant to section 210.027, RSMo, or any person over the age of eighteen (18) who is living in the applicant's home has been refused licensure or has experienced licensure suspension or revocation pursuant to section 210.221 or 210.496, RSMo; and

3. Request a criminal background check pursuant to section 43.540, RSMo, of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, and any person over the age of eighteen (18) who is living in the applicant's home.

(B) Except as otherwise provided in section (3) below, upon completion of the background checks required in subsection (2)(A) above, an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, shall be denied state or federal funds for providing child care if such applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, or any person over the age of eighteen (18) who is living in the applicant's home:

1. Has had a probable cause (or reason to suspect) finding of child abuse or neglect pursuant to section 210.145, RSMo;

2. Has been refused licensure or has experienced licensure suspension or revocation pursuant to section 210.496, RSMo; or

3. Has plead guilty or *nolo contendere* to or been found guilty of:

A. Any felony for an offense against the person as defined in Chapter 565, RSMo, or any other offense (misdemeanor or felony) against the person involving the endangerment of a child as prescribed by law;

B. Any misdemeanor or felony for a sexual offense as defined by Chapter 566, RSMo;

C. Any misdemeanor or felony for an offense against the family as defined in Chapter 568, RSMo, with the exception of the sale of fireworks to a child under the age of eighteen (18);

D. Any misdemeanor or felony for pornography or related offense as defined by Chapter 573, RSMo; or

E. Any similar crime in any federal, state, municipal or other court of similar jurisdiction of which the director has knowledge or any offenses or reports which will disqualify an applicant from receiving state or federal funds, including the following:

(I) Murder, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(II) Manslaughter, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(III) Assault, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(IV) Assault, in any degree, involving a child victim which is considered a misdemeanor or a felony in the jurisdiction in which it is filed; or

(V) Kidnapping, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VI) Felonious restraint or false imprisonment, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VII) Interference with child custodial rights, in any degree, which is considered a felony (or, if involving the endangerment of a child, either a misdemeanor or felony) in the jurisdiction in which it was filed; or

(VIII) Elder abuse, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(IX) Adult abuse or stalking, in any degree, which is considered a felony in the jurisdiction in which it was filed; or

(X) Any form of rape, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XI) Any form of sodomy, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XII) Any form of prostitution, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIII) Any form of child molestation, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIV) Any form of bigamy, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XV) Any form of child abandonment, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVI) Any form of criminal nonsupport of a child, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVII) Any form of child endangerment, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XVIII) Any form of child abuse, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XIX) Any form of robbery, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XX) Any form of arson, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXI) Any form of armed criminal action, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXII) Any form of unlawful possession, unlawful use, or unlawful transfer of a firearm, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXIII) Any form of unlawful promotion, unlawful possession, or unlawful furnishing of obscene or pornographic materials, including, but not limited to, child pornography, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXIV) Any form of unlawful possession, sale, transfer or trafficking (or any similar term in the jurisdiction in which the offense occurred) of a controlled substance, in any degree, which is considered a felony or a misdemeanor in the jurisdiction in which it was filed; or

(XXV) Any adjudication of guilt, any plea of guilty, or any plea of *nolo contendere* in a municipal court for conduct which if prosecuted in a court of general jurisdiction would be an offense described in part (2)(B)3.E.(I) through (XXIV) above.

(C) Any costs associated with such checks shall be paid by the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo.

(D) Identity of the name of the applicant, pursuant to section 210.025, RSMo; or a recipient, pursuant to section 210.027, RSMo; or any person over the age of eighteen (18) who is living in the home of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, and either such person's Social Security number or date of birth to the name and either the Social Security number or date of birth of the perpetrator of an incident of child abuse or neglect, or person who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or defendant in a criminal offense shall be sufficient to find that the applicant, pursuant to section 210.025, RSMo; or a recipient, pursuant to section 210.027, RSMo; or person over the age of eighteen (18) who is living in the home of the applicant is the same person who was found to have perpetrated the child abuse or neglect, or who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or who committed the criminal offense. The applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, may present evidence to rebut this presumption. However, the presumption survives the presentation of such evidence and may be sufficient to find that the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, or person over the age of eighteen (18) who is living in the home of the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, is the same person who was found to have perpetrated the child abuse or neglect, or who was subject to licensure suspension or revocation pursuant to section 210.496, RSMo, or who committed the criminal offense despite the presentation of contrary evidence.

(3) Extenuating or Mitigating Circumstances. Upon completion of background checks required by this rule, the division shall give an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, an opportunity to offer any extenuating or mitigating circumstances concerning adverse information found relating to findings of child abuse or neglect, licensure refusal or suspension, or criminal background checks against the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, or any person over the age of eighteen (18) who is living in the applicant's home. Such extenuation or mitigation may include, but is not limited to, the extent of the individual's participation in the abuse, neglect or offense; the length of time since the last incident of abuse, neglect or offense; the age of the person at the time of the abuse, neglect or offense; and remedial measures taken by the individual such as counseling, training, or therapy. In addition, the division may consider all information relating to any allegations of abuse or neglect including reports of investigation, if available. However, the fact that the report of investigation of an incident of abuse or neglect is no longer available, will not prevent the division from considering such a finding of abuse or neglect. Such a finding shall be considered along with any information the applicant wishes to present regarding the incident and any extenuating or mitigating information. Such extenuating or mitigating circumstances may be considered by the division in its determination whether to permit such applicant to receive state or federal funds for providing child care in the home.

(4) Family Care Safety Registry.

(A) The Family Care Safety Registry will contain criminal background information on only felony criminal offenses pursuant to Chapters 198, 334, 560, 565, 568, 569, 573, 575, and 578, RSMo (section 210.909.1(4), RSMo). Providers of in-home child care

services are not eligible to receive state or federal funds if they or members of their household over the age of eighteen (18) have criminal records involving Chapters 565 (felonies or any offense involving the endangerment of a child), 566 (misdemeanors or felonies), 568 (misdemeanors or felonies), 573 (misdemeanors or felonies), any offense which would disqualify the applicant or recipient from receiving state or federal funds, or of any similar crimes in any federal, state or municipal court.

(B) Because in-home child care providers are ineligible to receive state or federal funds for a different range of criminal offenses (for example, certain misdemeanors and similar crimes in any federal, state or municipal court) than would be included in the Family Care Safety Registry, applicants for direct payment or reimbursement of in-home child care services and members of their household over the age of eighteen (18) will be required to sign a request for criminal background check by the Missouri State Highway Patrol. The costs associated with this check shall be paid by the applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo.

(5) Evidence. In determining whether there has been a finding of probable cause to suspect (or reason to suspect) that child abuse or neglect has been committed by an applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, or a person over the age of eighteen (18) living in the applicant's home, the following shall be considered in evidence in making such determination:

(A) The letter, or a copy of the letter, from the Division of Family Services to the subject stating that there was probable cause to suspect (or reason to suspect) that the subject had committed child abuse or neglect;

(B) The letter, or a copy of the letter, from the Child Abuse and Neglect Review Board to the subject affirming the decision of the Division of Family Services which found that there was probable cause to suspect (or reason to suspect) that the subject had committed child abuse or neglect;

(C) A computer printout documenting either that the Division of Family Services made a probable cause (or reason to suspect) finding that child abuse or neglect occurred or that the Child Abuse and Neglect Review Board affirmed such finding which is otherwise authenticated pursuant to Chapter 490, RSMo, or with regard to which authentication is waived; or

(D) Any order, judgment or decree of a court of competent jurisdiction which found that the subject committed child abuse or neglect.

(E) The fact that any documentation regarding a finding of abuse or neglect, including but not limited to the report of investigation, cannot be found or has been destroyed shall not prevent that finding of abuse (otherwise documented in written or electronic form) from being considered by the division.

(6) Child Abuse or Neglect Findings. For purposes of disqualification, probable cause findings to suspect that child abuse or neglect occurred and reason to suspect findings that child abuse or neglect occurred shall be considered synonymous.

(7) All providers of child care services in the home pursuant to this rule shall be at least eighteen (18) years old, i.e., such providers must have attained their eighteenth birthday.

(8) If there are no local ordinances or regulations regarding smoke detectors which apply to the location where the provider will be providing child care services in the home, providers must install and maintain smoke detectors as follows:

(A) Structures Included. Smoke detectors shall be provided in all structures occupied by children in connection with child care services in the home.

(B) Location.

1. A detector shall be mounted on the ceiling or wall at a point centrally located in a corridor or other area giving access to rooms used for providing child care services in the home unless the manufacturer's instructions provide otherwise, then in accordance with those instructions.

2. All detectors shall be located in accordance with approved manufacturer's instructions. When actuated, the detectors shall provide an alarm in the structure or room.

(C) Duties.

1. It shall be the duty of the provider of child care services in the home regulated by this section to provide an operable smoke alarm system.

2. It shall be the duty of the provider of child care services in the home regulated by this section to maintain the smoke alarm system.

(9) All providers of child care services in the home regulated by this section shall be tested at least annually for tuberculosis. Initially providers of child care services in the home shall have a screening test (e.g., skin test). Any provider testing positive in the screening test shall submit, within one week of notice of the positive screening test, to additional, specific medical tests to verify the positive screening test and to determine if the provider is medically diagnosed with an active case of tuberculosis. If the provider is medically diagnosed with an active case of tuberculosis, the provider shall be ineligible to receive state or federal funds for the provision of child care services in the home while the medical diagnosis of an active case of tuberculosis remains.

(10) All providers, of child care services in the home, regulated by this section who do not have immediate access to a telephone shall notify the parents of the child(ren) of the lack of immediate access to a telephone and shall notify the parents of the child(ren) how the parents may contact the provider.

(11) Appeal. Any applicant, pursuant to section 210.025, RSMo, or a recipient, pursuant to section 210.027, RSMo, who has been denied state or federal funds for providing child care services in the home may appeal such denial decisions in accordance with the provisions of section 208.080, RSMo.

AUTHORITY: section 210.025, RSMo 2000. Emergency rule filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 19, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Division of Family Services, Denise Cross, P.O. Box 88, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register.*** *No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 45—Division of Legal Services
Chapter 2—State Technical Assistance Team

PROPOSED RULE

13 CSR 45-2.010 Organization and Operation

PURPOSE: This rule describes the general organization and function of the State Technical Assistance Team including its responsibilities in providing technical assistance to Child Fatality

Review Program (CFRP) panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality review. This rule also establishes and describes the functions of local (county) CFRP panels, as well as the state CFRP panel in this child protective services process.

(1) General Provisions and Authority. This rule is promulgated under the rulemaking authority granted to the Department of Social Services (DSS) pursuant to section 660.017, RSMo. Pursuant to Article IV, Section 37 of the *Missouri Constitution*, the director of the Department of Social Services is charged with promoting improved health and other social services to the citizens of the state as provided by law. Section 660.010.2, RSMo authorizes the DSS director to coordinate the state's programs devoted to those who are unable to provide for themselves and for victims of social disadvantage. Section 660.012.2 RSMo also entrusts the DSS director with the duty to use the resources allocated to the department to provide comprehensive programs and leadership in order to improve services and economical operations. To that end, the DSS director has determined that the transfer of the State Technical Assistance Team (STAT) from the Division of Family Services (DFS) to the Division of Legal Services (DLS) improves the efficiency and economical operations of resources and maximizes services to the citizens of this state. This rule recognizes that the transfer of STAT from DFS to DLS has been accomplished and such rule also provides a mechanism for the promulgation of procedures setting forth the function, general organization and operation of the State Technical Assistance Team. As a unit of the Division of Legal Services, STAT is responsible for performing its duties related to child fatality review pursuant to sections 210.192 to 210.196, RSMo and its duties related to providing assistance to multidisciplinary teams and law enforcement agencies in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality as prescribed in sections 660.520 to 660.527, RSMo. In performing its CFRP mission, STAT is responsible for providing training, expertise and assistance to county CFRP panels for the review of child fatalities including establishing procedures for the preparation and submission of a Final Report by CFRP panels as reflected in subsection (4)(K) of this rule.

(2) Definitions.

(A) Child abuse means any physical injury or emotional abuse inflicted on a child other than by accidental means by another person, except that discipline, including spanking, administered in a reasonable manner, shall not be construed to be abuse.

(B) Child exploitation means allowing, permitting or encouraging a child, under the age of eighteen years, to engage in prostitution or sexual conduct, as defined by state law, by a person responsible for the child's welfare or any other person involved in the act, and allowing, permitting, encouraging or engaging in the obscene or pornographic photographing, filming or depicting of a child, under the age of eighteen years, or the possession of such items, as those acts are defined by state law, by a person responsible for the child's welfare or any other person involved in the act.

(C) Child fatality means the death of a child under the age of eighteen years as a result of any natural, intentional or unintentional act.

(D) Child neglect means the failure to provide, by those responsible for the care, custody and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical or any other care necessary for the child's well-being.

(E) Child sexual abuse means to engage in sexual intercourse or deviate sexual intercourse with a child or any touching of a child with the genitals, or any touching of the genitals, or anus of the child by another person, when the child is a person under the age of seventeen years.

(3) State Technical Assistance Team.

(A) The State Technical Assistance Team shall assist in the investigation of child abuse, child neglect, child sexual abuse, child exploitation or child fatality cases upon the request of:

1. A local law enforcement agency;
2. Prosecuting attorney;
3. Division of Family Services staff;
4. A representative of the family courts;
5. Medical examiner;
6. Coroner; or
7. Juvenile officer.

(B) Upon being requested to assist in an investigation, the State Technical Assistance Team shall notify all parties specified in subsection (3)(A) of STAT's involvement in the investigation via U.S. Postal Service.

(C) Where STAT's assistance has been requested by a local law enforcement agency, STAT investigators, certified as peace officers by the director of the Department of Public Safety pursuant to Chapter 590, RSMo shall be deemed to be peace officers within the jurisdiction of the requesting law enforcement agency, while acting at the request of the law enforcement agency. The power of arrest of a STAT investigator, acting as a peace officer, shall be limited to offenses involving child abuse, child neglect, child sexual abuse, child exploitation or child fatality.

(D) STAT shall assist county multidisciplinary teams in the development and implementation of protocols for the investigation and prosecution of child abuse, child neglect, child sexual abuse, child exploitation or child fatality cases.

(E) All reports and records made and maintained by the STAT or local law enforcement relating to criminal investigations conducted pursuant to this section, including arrests, shall be available in the same manner as law enforcement records, as set forth in sections 610.100 to 610.200, RSMo, and to the individuals identified in subdivision (13) of subsection 2 of section 210.150, RSMo.

(F) An individual identified in subdivision (13) of subsection 2 of section 210.150, RSMo, is a person who is a tenure-track or full-time research faculty member at an accredited institution of higher education engaged in scholarly research and who has the permission of the director of the Department of Social Services. Prior to the release of any identifying information the director of the DSS shall require the researcher to present a plan for maintaining the confidentiality of the identifying information. The researcher shall be prohibited from releasing the identifying information of individual cases.

(G) All other records shall be available in the same manner as provided in section 210.150, RSMo. Nothing in this section shall preclude the release of findings or information about cases which resulted in a child fatality or near fatality. Such release is at the sole discretion of the director of the Department of Social Services, based upon the review of the potential harm to other children with the immediate family.

(4) Local (County) Child Fatality Review Program (CFRP) Panels.

(A) The prosecuting attorney or circuit attorney shall convene a local CFRP panel in each of the state's one hundred fourteen counties and St. Louis City to review suspicious child deaths.

(B) The Department of Social Services (DSS) shall convene a state CFRP panel appointed by the director of DSS to identify systemic problems and submit findings and recommendations on ways to prevent further child deaths.

(C) The local CFRP panel will review all deaths of children less than eighteen years of age at the time of their death where one or more of the following factors are present:

1. Sudden, unexplained death of a child under age one year;
2. Unexplained/undetermined manner;
3. DFS reports on decedent or other persons in the residence;
4. Decedent in DFS custody;
5. Possible inadequate supervision of the decedent;
6. Possible malnutrition or delay in seeking medical care;

7. Possible suicide;
8. Possible inflicted injury;
9. Firearm injury;
10. Injury not witnessed by person in charge of child at time of injury;
11. Confinement;
12. Suspicious/criminal activity;
13. Drowning;
14. Suffocation or strangulation;
15. Poison/chemical/drug ingestion;
16. Severe unexplained injury;
17. Pedestrian/bicycle/driveway injury;
18. Drug/alcohol-related vehicular injury;
19. Suspected sexual assault;
20. Fire injury;
21. Autopsy by certified child death pathologist;
22. Panel discretion; or
23. Other suspicious findings (injuries such as electrocution, crush or fall).

(D) The local CFRP panel at least shall review the following information on all suspicious deaths:

1. Findings from interviews, history or death-scene investigation;
2. Physical evidence at the scene of injury, death, or both;
3. Findings from physical and medical examinations;
4. Findings from autopsy, radiological examination and laboratory evaluation;
5. Reports of investigation/evaluation; and
6. Relevant past history/agency involvement.

(E) The director of DSS shall appoint regional coordinators to serve as resources to local CFRP panels. The regional coordinators will provide the following services:

1. Consultation and technical assistance;
2. Training; and
3. Reviewing forms and provide recommendations on procedures developed by local panels.

(F) Initially, all panel members will be appointed by the prosecuting attorney. Subsequent appointments will be made by the chairperson. All members who represent a governmental agency defined as mandatory in this section will serve as long as they hold the position which made them eligible for appointment to the local CFRP panel. All other members shall serve a term which is defined in the procedures developed by the local panel. The local procedures also shall define the selection and removal processes for non-core members. The chairperson shall be elected by the review panel. The chairperson and all other members may be reappointed for consecutive terms. The local CFRP panel shall include, but not be limited to, the following core members:

1. The prosecuting or circuit attorney;
2. Medical examiner/coroner;
3. A law enforcement officer;
4. A representative of the DFS;
5. A provider of public health services;
6. A representative of the juvenile court; and
7. A representative of emergency medical services.

(G) If the county of residence, illness/injury/event or death are different, the CFRP panel in the county where the illness/injury/event occurred shall review the death.

1. The activated review panel may communicate with the chairperson of the CFRP panel in the county of residence and death, if different, to request necessary information.

2. The review panel in the county of death, residence, or both, may choose to review the death.

3. The Coroner/Medical Examiner Data Report (Data Form 1), which is hereby incorporated by reference as part of this rule, must be completed on all children ages birth through seventeen (0-17) who die in Missouri, regardless of state of residence.

4. Children injured out of state, who die in Missouri, may be reviewed at the sole discretion of the county panel, regardless of state of residence.

(H) The panel members will hold all information obtained in the course of a review in the strictest confidence and will not discuss or disclose any information regarding any case, except as permitted by applicable statutes.

(I) DLS will not reimburse or compensate a county CFRP panel for expenses associated with review panel business. Expenses may be reimbursed consistent with state travel rules and limitations for required participation of DLS panel members in training. DFS will be responsible for payment of expenses, subject to state travel rules and limitations, and compensation for its employees who are members of a review panel.

(J) The following process will be followed by the county CFRP panels:

1. Any police officer, sheriff, law enforcement officer or official, physician, coroner/medical examiner, funeral director, hospital personnel or any person having knowledge that a person less than eighteen years of age has died, shall notify the coroner or medical examiner immediately in the county of injury.

A. If the coroner or medical examiner in the county of death or residence is notified of a death, s/he shall notify the coroner or medical examiner immediately in the county of illness/injury/event, if different.

B. If the coroner or medical examiner in the county of illness/injury/event determines that the death of the person under age eighteen does not exhibit any suspicious circumstances as described in this section, the panel chairperson will be responsible for cosigning Data Form 1, which is incorporated by reference as part of this rule, and shall forward the form within forty-eight hours to the DSS, STAT. If the chairperson disagrees with the coroner or medical examiner regarding the nature of the death and desires a review, the review panel can be activated.

C. The coroner or medical examiner in the county of illness/injury/event shall notify a certified child death pathologist to determine the need for an autopsy. If there is disagreement, the certified child death pathologist shall make the determination, unless the CFRP panel, within twelve (12) hours, decides against the certified child death pathologist;

D. If the coroner or medical examiner determines that the child died from natural causes while under medical care, such coroner or medical examiner shall notify DFS (Central Registry Unit, "Child Abuse/Neglect Hotline"—800-392-3738). In all other cases, the medical examiner or coroner shall immediately notify DFS of the child's death, as required by section 58.452, RSMo.

2. The coroner or medical examiner in the county of illness/injury/event shall notify the chairperson of the CFRP panel immediately if the death is suspicious;

3. Upon notification, the chairperson will activate the review panel within twenty-four hours to review the death.

A. Each member of the panel shall share information and records available to that panel member.

B. Each review panel shall operate the review based on procedures developed by the panel and based on guidelines and protocols developed by the DSS;

4. The review panel shall determine, at a minimum:

A. The place where the injury/illness causing a death occurred;

B. The manner and circumstances of the death;

C. Actions taken by the agencies/persons involved with the child and his/her family;

D. The identification of any siblings or other children in the home of the deceased child and whether they require protection; and

E. The identification of local systemic issues or policies which enhance or detract from efforts to assist in the investigation, treatment or prevention of fatalities; and

5. The chairperson of the local CFRP panel will complete Data Form 2, which is incorporated by reference as part of this rule, and forward it through to the DSS, STAT, for linkage with death certificates. This form must be sent within sixty (60) days of the date of death.

(K) Final Report.

1. In all cases reviewed by a CFRP panel, the CFRP shall, after completing the review, prepare a Final Report which shall consist of a summary of prevention conclusions and recommendations. The Final Report shall be submitted on a form referred to as the Child Fatality Review Panel Final Report (or Final Report), which is incorporated by reference as part of this rule. Pursuant to section 210.192.3, RSMo 2000 the Final Report issued by the panel is a public record and may be obtained by submitting a written request to the following address: State Technical Assistance Team, Division of Legal Services, 2724 Merchants Drive, Jefferson City, MO 65109.

2. The CFRP panel's Final Report will be forwarded directly to the State Technical Assistance Team, prevention coordinator, within ten (10) days of the CFRP panel review, except in cases where criminal charges are being considered or pending. In those cases, the final report of the panel will be due within ten (10) days after a criminal indictment or information is filed in the case or the local panel chair is notified of the prosecutor's decision not to file charges.

3. The prevention coordinator will be a direct liaison with all CFRP panels, maintaining a prevention resource repository, and providing guidance and facilitation in the implementation of appropriate prevention strategies and responses.

4. Separate from data collected, the prevention coordinator will track the effectiveness of various prevention responses to specific risks, and will make this information available to the state CFRP panel and appropriate supporting agencies.

(5) State Child Fatality Review Panel.

(A) The state CFRP panel shall be composed of a minimum of seven members. All members will be appointed by the director of the DSS.

1. Members mandated by this rule to be members of this panel may serve as long as they hold the position which made them eligible for appointment.

2. The DSS shall establish procedures which define the terms for all members, reasons for the removal of members from the panel and how members will be appointed in the future.

3. The chairperson and all members may be reappointed for consecutive terms.

(B) The director of DSS shall appoint the following persons to serve on the state CFRP panel:

1. A prosecuting attorney or circuit attorney;
2. A coroner or medical examiner;
3. A law enforcement officer or official;
4. A representative from DFS;
5. A provider of public health care services;
6. A representative from the Department of Health;
7. A representative of the juvenile court; and
8. A representative of emergency medical services.

(C) Other members of the state CFRP panel may include persons from the following agencies/groups:

1. Division of Youth Services;
2. Attorney General;
3. Missouri Juvenile Justice Association;
4. A physician experienced in examining and treating abused/neglected children;
5. Department of Mental Health;
6. Department of Public Safety;
7. Department of Elementary and Secondary Education;
8. Department of Corrections; and
9. Any other professionals or citizens with special interest in child abuse and neglect.

(D) The state CFRP panel will meet at least biannually. DLS may reimburse the members who are not division employees for reasonable expenses, consistent with state travel rules and limitations for expenses associated with review panel business held outside their county of residence, but will not provide for any other compensation. DFS will be responsible for the reimbursement of expenses, subject to state travel rules and limitations, and compensation for its employees on the panel.

(E) The state CFRP panel shall review and discuss all relevant materials submitted by the local panels and the state implementation team. The purpose of the review will be to:

1. Review the findings of the county CFRP panels to determine the frequency and cause of child fatalities throughout the state;
2. Identify the appropriateness and comprehensiveness of current statutes, policies and procedures relevant to the management of fatal abuse/neglect cases;
3. Review data collected by the DSS, STAT to determine the accuracy of identification of fatally abused and neglected children;
4. Review reports on the status of the operations of the county CFRP panels; and
5. Recommend prevention strategies after reviewing statewide trends and actions suggested by local panels.

(F) The panel members will hold all information obtained in the course of a review in the strictest confidence and will not discuss or disclose any information regarding any case, except as permitted by applicable statutes.

(G) DSS and the state CFRP panel annually shall evaluate the following factors related to the work of the local CFRP panels:

1. Number of reviews;
2. Geographic area of reviews;
3. Results of reviews; and
4. Necessary amendments to the rules.

(H) The state CFRP panel shall submit findings and recommendations to the director of DSS, the governor, the speaker of the house of representatives, the president *pro tempore* of the senate, and the children's services commission, juvenile officers and chairperson of the local CFRP panels. At a minimum, the findings shall address the following issues:

1. The number of child fatality cases reviewed by county panels;
2. Nonidentifying characteristics for perpetrators;
3. Nonidentifying characteristics for deceased children;
4. The number of fatalities by cause(s) of death and whether death was attributable to child abuse/neglect;
5. Effectiveness of local panels; and
6. Systemic issues which need to be addressed through changes in policy, procedures or statute.

AUTHORITY: sections 210.192–210.196, 660.017, 660.520 –660.527, RSMo 2000. Emergency rule filed Dec. 19, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 19, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Division of Legal Services, State Technical Assistance Team, 2724 Merchants Drive, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CORONER/MEDICAL EXAMINER DATA REPORT

TO BE COMPLETED FOR ALL CHILD DEATHS <18 YEARS OF AGE

STATE USE ONLY		DATA FORM 1
DEATH CERT. NO.	BIRTH CERT. NO.	
CFRP CASE NO.	DECEDENT DCN	
☐ MEDICAID	CA/N INCIDENT NO.	

DEATH CERTIFICATE MANNER OF DEATH
a. ☐ NATURAL d. ☐ HOMICIDE
b. ☐ ACCIDENT e. ☐ UNDETERMINED
c. ☐ SUICIDE f. ☐ PENDING

INSTRUCTIONS

Notify Child Abuse/Neglect Hotline (800-392-3738) of all deaths of children <18 years of age.

If county of illness/injury/event is different from county of death, complete form with all known information before forwarding to coroner or medical examiner of county of illness/injury/event.

Notify the panel chairperson of the death.

Complete the form with all known information and forward to the panel chairperson for signature.

A. IDENTIFICATION INFORMATION

1.
a. ☐ Illness/injury/event is in Missouri. Complete all sections of Form 1.
b. ☐ Illness/injury/event occurred out-of-state, but death occurred in Missouri. Complete Section A only.

2. COUNTY OF RESIDENCE (STATE USE ONLY)	3. COUNTY OF ILLNESS/INJURY/EVENT (STATE USE ONLY)	4. COUNTY OF DEATH (STATE USE ONLY)

5. DECEDENT'S NAME (FIRST, MI, LAST)	6. DATE OF BIRTH (MM/DD/YY)	7. DATE OF DEATH (MM/DD/YY)
/ /	__ __/__ __/__ __	__ __/__ __/__ __

8. SEX	9. RACE	10. IS DECEDENT OF HISPANIC ORIGIN?
a. ☐ MALE	a. ☐ WHITE c. ☐ ASIAN/PACIFIC ISLANDER e. ☐ UNKNOWN	a. ☐ YES b. ☐ NO
b. ☐ FEMALE	b. ☐ BLACK d. ☐ AMERICAN INDIAN/ALASKAN NATIVE	

11. MOTHER'S NAME (FIRST, MAIDEN, LAST)	12. MOTHER'S DATE OF BIRTH
/ /	__ __/__ __/__ __

B. INDICATIONS FOR REVIEW — (ALL DEATHS)

1. Mark **all** that apply to this fatality. If one or more indicators are applicable, RSMo. 210.192 requires that the case **shall be referred** to the panel.

a. ☐ Sudden, unexplained death, age <1 year
b. ☐ Unexplained/undetermined manner
c. ☐ DFS reports on decedent or other persons in the residence
d. ☐ Decedent in DFS custody
e. ☐ Possible inadequate supervision
f. ☐ Possible malnutrition or delay in seeking medical care
g. ☐ Possible suicide
h. ☐ Possible inflicted injury
i. ☐ Firearm injury
j. ☐ Injury not witnessed by person in charge at time of injury
k. ☐ Confinement
l. ☐ Suspicious/criminal activity
m. ☐ Drowning
n. ☐ Suffocation or strangulation
o. ☐ Poison/chemical/drug ingestion
p. ☐ Severe unexplained injury
q. ☐ Pedestrian/bicycle/driveway injury
r. ☐ Motor vehicle injury
s. ☐ Suspected sexual assault
t. ☐ Fire injury
u. ☐ Autopsy by certified child death pathologist
v. ☐ Panel discretion
w. ☐ Other suspicious findings (injuries such as electrocution, crush or fall)

2. Referral to Panel (Mark one)

a. ☐ One or more of the indicators marked above apply in this fatality. The case **shall be referred** to the review panel.
b. ☐ None of the indicators listed apply in this fatality. The case is not referred to the panel.

C. CHILD ABUSE/NEGLECT HOTLINE (800-392-3738)

Notify Child Abuse/Neglect Hotline of all deaths of children <18 years of age.

1. Were there prior reports to the Child Abuse/Neglect Hotline? a. ☐ Yes b. ☐ No
If yes, mark all that apply:

1. ☐ Involving child
2. ☐ Involving anyone else in family
3. ☐ Involving caretaker (other than family)
4. ☐ Total number of DFS reports _____

2. Current notification to Child Abuse/Neglect Hotline was accepted as:

a. ☐ Information only b. ☐ Report for investigation

3. Person reporting death to the hotline? _____

D. SOCIAL INFORMATION

1. For all persons living in the residence of the decedent, indicate their relationship to the decedent, their age range, and who is head of household. (Select only one head of household)

Use corresponding letter for appropriate age range:

A = 0-5 yrs. **B** = 6-9 yrs. **C** = 10-14 yrs. **D** = 15-18 yrs. **E** = 19-40 yrs. **F** = >40 yrs.

	Age Range	Head of Household		Age Range	Head of Household
a. ☐ Natural father	____	☐	i. ☐ Other relative	____	☐
b. ☐ Natural mother	____	☐	j. ☐ Other relative	____	☐
c. ☐ Adoptive father	____	☐	k. ☐ Mother's paramour	____	☐
d. ☐ Adoptive mother	____	☐	l. ☐ Father's paramour	____	☐
e. ☐ Stepfather	____	☐	m. ☐ Other non-relative	____	☐
f. ☐ Stepmother	____	☐	n. ☐ Another child	____	☐
g. ☐ Foster father	____	☐	o. ☐ Another child	____	☐
h. ☐ Foster mother	____	☐	p. ☐ More than two children (list in narrative)		

2. Current marital status of head of household?

a. ☐ Married c. ☐ Divorced e. ☐ Unknown
b. ☐ Widowed d. ☐ Never married

E. DEATH/SCENE INFORMATION

1. Place of Injury/Event?

a. ☐ Decedent's home e. ☐ Public drive i. ☐ Other private property m. ☐ Body of water
b. ☐ Other home f. ☐ Street j. ☐ Licensed child care facility n. ☐ Work place
c. ☐ Rural road g. ☐ Private drive k. ☐ Unlicensed child care facility o. ☐ Hospital
d. ☐ Highway h. ☐ Farm l. ☐ Child care residential facility p. ☐ Other: _____

2. Date of injury/event? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY) b. ☐ Unknown

3. Time of injury/event? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

4. Time pronounced dead? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

5. Was an autopsy performed? a. ☐ Yes b. ☐ No c. ☐ Unknown

If yes:
1. ☐ By CFRP pathologist?
2. ☐ By hospital physician?

NOTE: Autopsies performed by non-certified Child Death Pathologists are limited to hospital deaths resulting from a **known** medical condition/illness. All others are to be done by a Child Death Pathologist (see listing at www.dss.state.mo.us/stat/cpn.htm). Only CFRP pathologist autopsies qualify for reimbursement.

3. Name of CFRP pathologist? (Last name only) _____

F. SUPERVISION

1. Who was in charge of watching the decedent at the time of injury/event?

a. ☐ Natural father g. ☐ Foster father m. ☐ Unlicensed babysitter/child care worker
b. ☐ Natural mother h. ☐ Foster mother n. ☐ Child, age: _____
c. ☐ Adoptive father i. ☐ Other relative o. ☐ Hospital staff
d. ☐ Adoptive mother j. ☐ Parent's male paramour p. ☐ Other non-relative
e. ☐ Stepfather k. ☐ Parent's female paramour q. ☐ No one in charge of watching
f. ☐ Stepmother l. ☐ Licensed babysitter/child care worker r. ☐ Due to age, no one in charge

2. Was the decedent adequately supervised? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

If no:

1. Did the person(s) in charge appear to be intoxicated, under influence of drugs, mentally ill or limited, or otherwise impaired at time of injury/event?
   a. ☐ Yes b. ☐ No c. ☐ Unknown

2. Was the person(s) preoccupied, distracted or asleep at the time of the injury/event?
   a. ☐ Yes b. ☐ No c. ☐ Unknown

3. Was injury/event witnessed by at least one person? a. ☐ Yes b. ☐ No c. ☐ Unknown

G. CAUSE OF DEATH

(Select most appropriate cause of death and if applicable, complete Section H)

1. ☐ INJURY (Complete questions 1 and 2 for all injuries)

1. Was the injury inflicted? a. ☐ Yes b. ☐ No c. ☐ Unknown
   (Inflicted - defined as assaultive or aggressive action)
2. Was the injury intentional? a. ☐ Yes b. ☐ No c. ☐ Unknown

If vehicle accident, non-reviewable, answer questions 3 through 9. If reviewable vehicle accident (pedestrian/bicycle/driveway injury, drug/alcohol related or other suspicious/criminal activity), skip the following questions and complete Section H.

3. Position of decedent?
   a. ☐ Operator c. ☐ Other
   b. ☐ Passenger d. ☐ Unknown
4. Vehicle in which decedent was occupant?
   a. ☐ Car c. ☐ Motorcycle/ATV e. ☐ Semi/Tractor trailer unit
   b. ☐ Truck/RV/Van d. ☐ Farm vehicle f. ☐ Other
5. Was another vehicle involved in accident? a. ☐ Yes b. ☐ No
6. Condition of road?
   a. ☐ Normal c. ☐ Wet e. ☐ Other
   b. ☐ Loose gravel d. ☐ Ice or snow f. ☐ Unknown
7. Restraint used by decedent?
   a. ☐ Present, not used c. ☐ Used correctly e. ☐ Unknown
   b. ☐ None in vehicle d. ☐ Used incorrectly f. ☐ Not applicable
8. Helmet used by decedent?
   a. ☐ Helmet worn b. ☐ Helmet not worn c. ☐ Not applicable
9. Primary cause of accident?
   a. ☐ Speeding c. ☐ Mechanical failure e. ☐ Driver error
   b. ☐ Carelessness d. ☐ Weather conditions f. ☐ Other

2. ☐ ILLNESS OR OTHER NATURAL CAUSE

1. Known condition _____
2. Was inadequate care or neglect involved in death? a. ☐ Yes b. ☐ No
   (If yes, mark Section H, Number 2)

Complete questions 3 - 8 if death in infant <1 year of age.

3. History information provided by? a. ☐ Parent b. ☐ Physician/Medical facility c. ☐ Other
4. Age at death?
   a. ☐ 0 - 24 hours after birth c. ☐ 48 hours - 6 weeks e. ☐ 6 months - 1 year
   b. ☐ 24 - 48 hours d. ☐ 6 weeks - 6 months
5. Gestational age?
   a. ☐ <25 weeks b. ☐ 25 - 30 weeks c. ☐ 30-37 weeks d. ☐ >37 weeks e. ☐ Unknown
6. Birth weight in grams (approximate lbs./oz.)?
   a. ☐ <750 (<1 lb. 10 oz.) c. ☐ 1,500 - 2,499 (3 lbs. 6 oz. to 5 lbs. 5 oz.) e. ☐ Unknown
   b. ☐ 750 - 1,499 (1 lb. 10 oz. to 3 lbs. 5 oz.) d. ☐ >2,500 (>5 lbs. 6 oz.)
7. Multiple birth? a. ☐ Yes b. ☐ No
8. Have there been other infant deaths in the immediate family? a. ☐ Yes b. ☐ No c. ☐ Unknown

3. ☐ UNKNOWN CAUSE (Describe in narrative. Death shall be reviewed.)

1. Was death sudden and unexplained in infant <1 year of age, but over 1 week old? a. ☐ Yes b. ☐ No
   (If yes, the child is required to be autopsied by child death pathologist)
   If yes, also complete Section G, Number 2, questions 3 - 8 and mark Section H, Number 1.

H. CIRCUMSTANCES OF DEATH

If any of the circumstances are applicable, death shall be reviewed.

1. ☐ Sudden Unexplained Death of Infant <1 Year
2. ☐ Inadequate Care or Neglect
3. ☐ Vehicular
   (Includes pedestrian/bicycle/driveway injury, drug/alcohol related, or other suspicious/criminal activity)
4. ☐ Drowning
5. ☐ Firearm
6. ☐ Suffocation/Strangulation
7. ☐ Electrocution
8. ☐ Fall Injury
9. ☐ Poisoning/Overdose
10. ☐ Fire/Burn
11. ☐ Crush
12. ☐ Confinement
13. ☐ Shaker/Impact Syndrome
14. ☐ Other Inflicted Injury
    (Describe in narrative)
15. ☐ Other Circumstances
    (Describe in narrative)

I. NARRATIVE DESCRIPTION OF CIRCUMSTANCES OR OTHER COMMENTS

SEND COMPLETED DATA FORM 1 TO:

STATE TECHNICAL ASSISTANCE TEAM
2724 MERCHANTS DRIVE, JEFFERSON CITY, MO 65109
573-751-5980 OR 800-487-1626
FAX: 573-751-1479

CORONER/MEDICAL EXAMINER SIGNATURE ▶	REFER TO CFRP? a. ☐ YES b. ☐ NO	DATE (MM/DD/YY) __ __/__ __/__ __
CFRP CHAIR SIGNATURE ▶	REFER TO CFRP? a. ☐ YES b. ☐ NO	DATE (MM/DD/YY) __ __/__ __/__ __
REGIONAL COORDINATOR SIGNATURE		DATE (MM/DD/YY) __ __/__ __/__ __

MO 886-3219 (10-00) PAGE 4

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CHILD FATALITY REVIEW PANEL DATA REPORT

TO BE COMPLETED FOR ALL REVIEWABLE CHILD DEATHS <18 YEARS OF AGE

STATE USE ONLY		DATA FORM 2
DEATH CERT. NO.	BIRTH CERT. NO.	
CFRP CASE NO.	DECEDENT DCN	
☐ MEDICAID	CA/N INCIDENT NO.	

INSTRUCTIONS

Notify Child Abuse/Neglect Hotline (800-392-3738) of all deaths of children <18 years of age.

Complete the form with all known information and forward to the regional coordinator within forty-five days of the death.

DEATH CERTIFICATE MANNER OF DEATH
a. ☐ NATURAL d. ☐ HOMICIDE
b. ☐ ACCIDENT e. ☐ UNDETERMINED
c. ☐ SUICIDE f. ☐ PENDING

A. IDENTIFICATION INFORMATION

1. COUNTY OF RESIDENCE (STATE USE ONLY)	2. COUNTY OF ILLNESS/INJURY/EVENT (STATE USE ONLY)	3. COUNTY OF DEATH (STATE USE ONLY)

4. DECEDENT'S NAME (FIRST, MI, LAST)	5. DATE OF BIRTH (MM/DD/YY)	6. DATE OF DEATH (MM/DD/YY)
/ /	__ __/__ __/__ __	__ __/__ __/__ __

7. SEX	8. RACE	9. IS DECEDENT OF HISPANIC ORIGIN?
a. ☐ MALE	a. ☐ WHITE c. ☐ ASIAN/PACIFIC ISLANDER e. ☐ UNKNOWN	a. ☐ YES b. ☐ NO
b. ☐ FEMALE	b. ☐ BLACK d. ☐ AMERICAN INDIAN/ALASKAN NATIVE	

10. MOTHER'S NAME (FIRST, MAIDEN LAST)	11. MOTHER'S DATE OF BIRTH (MM/DD/YY)
/ /	__ __/__ __/__ __

B. CHILD ABUSE/NEGLECT HOTLINE (800-392-3738)

1. Were there prior reports to the Child Abuse/Neglect Hotline? a. ☐ Yes b. ☐ No

   If yes, mark all that apply:

   1. ☐ Involving child
   2. ☐ Involving anyone else in family
   3. ☐ Involving caretaker (other than family)
   4. ☐ Total number of DFS reports _____

2. Current notification to Child Abuse/Neglect Hotline was accepted as:

   a. ☐ Information/Referral only b. ☐ Report for investigation

C. SOCIAL INFORMATION

1. For all persons living in the residence of the decedent, indicate their relationship to the decedent, their age range, and who is head of household. (Select only one head of household)

Use corresponding letter for appropriate age range:

A = 0-5 yrs. **B** = 6-9 yrs. **C** = 10-14 yrs. **D** = 15-18 yrs. **E** = 19-40 yrs. **F** = >40 yrs.

	Age Range	Head of Household		Age Range	Head of Household
a. ☐ Natural father	_____	☐	i. ☐ Other relative	_____	☐
b. ☐ Natural mother	_____	☐	j. ☐ Other relative	_____	☐
c. ☐ Adoptive father	_____	☐	k. ☐ Mother's paramour	_____	☐
d. ☐ Adoptive mother	_____	☐	l. ☐ Father's paramour	_____	☐
e. ☐ Stepfather	_____	☐	m. ☐ Other non-relative	_____	☐
f. ☐ Stepmother	_____	☐	n. ☐ Another child	_____	☐
g. ☐ Foster father	_____	☐	o. ☐ Another child	_____	☐
h. ☐ Foster mother	_____	☐	p. ☐ More than two children (list in narrative)		

2. Current marital status of head of household?

   a. ☐ Married c. ☐ Divorced e. ☐ Unknown
   b. ☐ Widowed d. ☐ Never married

D. DEATH/SCENE INFORMATION

1. Place of death?

a. ☐ Decedent's home
b. ☐ Other home
c. ☐ Rural road
d. ☐ Highway
e. ☐ Public drive
f. ☐ Street
g. ☐ Private drive
h. ☐ Farm
i. ☐ Other private property
j. ☐ Licensed child care facility
k. ☐ Unlicensed child care facility
l. ☐ Child care residential facility
m. ☐ Body of water
n. ☐ Work place
o. ☐ Hospital
p. ☐ Other: _____

2. Date of injury/event? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY) b. ☐ Unknown

3. Time of injury/event? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

4. Time pronounced dead? a. ☐ __ __ : __ __ (Hour:Minute) ☐ AM ☐ PM b. ☐ Unknown

5. Autopsy performed by? a. ☐ CFRP Pathologist (Last Name Only) _____
b. ☐ Not performed

E. SUPERVISION

1. Who was in charge of watching the decedent at the time of injury/event?

a. ☐ Natural father
b. ☐ Natural mother
c. ☐ Adoptive father
d. ☐ Adoptive mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster father
h. ☐ Foster mother
i. ☐ Other relative
j. ☐ Parent's male paramour
k. ☐ Parent's female paramour
l. ☐ Licensed babysitter/child care worker
m. ☐ Unlicensed babysitter/child care worker
n. ☐ Child, age: _____
o. ☐ Hospital staff
p. ☐ Other non-relative
q. ☐ No one in charge of watching
r. ☐ Due to age, no one in charge

2. Was the decedent adequately supervised? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

If no:

1. Did the person(s) in charge appear to be intoxicated, under influence of drugs, mentally ill or limited, or otherwise impaired at time of injury/event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

2. Was the person(s) preoccupied, distracted or asleep at the time of the injury/event?
a. ☐ Yes b. ☐ No c. ☐ Unknown

3. Was injury/event witnessed by at least one person? a. ☐ Yes b. ☐ No c. ☐ Unknown

F. PANEL FINDINGS

1. Date of first panel meeting? a. ☐ __ __ / __ __ / __ __ (MM/DD/YY)

2. Panel members participating?

a. ☐ Coroner
b. ☐ Prosecutor
c. ☐ DFS worker
d. ☐ Public health/Physician
e. ☐ EMS
f. ☐ Medical examiner
g. ☐ Law enforcement officer
h. ☐ Juvenile officer
i. ☐ Optional member
j. ☐ Optional member

3. Total number of meetings held? a. ☐ One b. ☐ Two c. ☐ Three or more

4. Death scene investigation conducted? (Mark all that apply)

a. ☐ By law enforcement
b. ☐ By coroner
c. ☐ By medical examiner
d. ☐ By EMS
e. ☐ By fire investigator
f. ☐ By other agency
g. ☐ Not conducted

5. Investigation by law enforcement?

a. ☐ Conducted, no arrest b. ☐ Conducted, arrest for: _____ c. ☐ Pending d. ☐ Not conducted

6. Investigation/evaluation by juvenile officer?

a. ☐ Conducted, no action b. ☐ Conducted, juvenile court action c. ☐ Pending d. ☐ Not conducted

7. Review of records by Department of Health?

a. ☐ Conducted, no action b. ☐ Conducted, services provided c. ☐ Pending d. ☐ Not conducted

MO 886-3218 (4-99)

CONTINUE ON PAGE 3

8. Review of history by Division of Family Services?

a. ☐ Conducted, no action c. ☐ Conducted, case investigation e. ☐ Not conducted
b. ☐ Conducted, services provided d. ☐ Pending

9. Action by prosecutor?

a. ☐ Suspected perpetrator, no charge filed c. ☐ Pending or in progress
b. ☐ Charge filed for: _____ d. ☐ No action

10. Review of medical/trip records by EMS?

a. ☐ Conducted, no action b. ☐ Conducted, services provided c. ☐ Pending d. ☐ Not conducted

11. Did the review lead to additional investigation? a. ☐ Yes b. ☐ No

12. Were additional services provided as a result of the review? a. ☐ Yes b. ☐ No

13. Were changes in agency policies or practices recommended as a result of the review? a. ☐ Yes b. ☐ No

G. PERSON(S) ARRESTED/CHARGED

If no arrest or charge, go to Section H

1. Number of person(s) arrested/charged? a. ☐ One b. ☐ Two c. ☐ Three or more

2. Number of persons arrested or charged under 18 years of age?

a. ☐ One b. ☐ Two c. ☐ Three or more d. ☐ Not applicable

3. Was one or more of the persons arrested or charged responsible for supervision of the child at time of fatal illness/injury/event?

a. ☐ Yes b. ☐ No

4. Indicate the relationship of the person(s) arrested or charged to the decedent.

a. ☐ Natural father
b. ☐ Natural mother
c. ☐ Adoptive father
d. ☐ Adoptive mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster father
h. ☐ Foster mother
i. ☐ Other relative
j. ☐ Sibling
k. ☐ Parent's male paramour
l. ☐ Parent's female paramour
m. ☐ Babysitter/child care worker
n. ☐ Friend
o. ☐ Acquaintance
p. ☐ Other non-relative
q. ☐ Other non-relative
r. ☐ Stranger

H. CAUSE OF DEATH

Complete Section appropriate to death

1. ☐ **INJURY (If marked, also complete Section I)**

1. Was the injury inflicted? a. ☐ Yes b. ☐ No c. ☐ Unknown
(Inflicted - defined as assaultive or aggressive action)

2. Was the injury intentional? a. ☐ Intentional b. ☐ Unintentional/Accidental c. ☐ Unknown

3. If intentional, was decedent? a. ☐ Intended victim b. ☐ Random victim

4. Person(s) inflicting injury? (Mark all that apply)

a. ☐ Self
b. ☐ Mother
c. ☐ Father
d. ☐ Stepmother
e. ☐ Stepfather
f. ☐ Mother's paramour
g. ☐ Father's paramour
h. ☐ Foster parent
i. ☐ Other relative
j. ☐ Acquaintance
k. ☐ Friend
l. ☐ Child care worker
m. ☐ Sibling
n. ☐ Other child
o. ☐ Stranger
p. ☐ Unknown

5. Age of primary person inflicting injury? a. ☐ _____ b. ☐ Unknown

6. Race of primary person inflicting injury?

a. ☐ White
b. ☐ Black
c. ☐ Asian/Pacific Islander
d. ☐ American Indian/Alaskan Native
e. ☐ Unable to determine
f. ☐ Unknown

MO 886 3218 (4-99) CONTINUE ON PAGE 4 PAGE 3

7. Was the injury drug related? a. ☐ Yes b. ☐ No c. ☐ Unknown

8. Was the injury gang related? a. ☐ Yes b. ☐ No c. ☐ Unknown

9. Did the injury occur during commission of a crime? a. ☐ Yes b. ☐ No c. ☐ Unknown

10. If suicide: (Mark all that apply)

a. ☐ Prior attempts
b. ☐ Talked of suicide
c. ☐ Prior mental health problems
d. ☐ Had previously received mental health services
e. ☐ Suicide completely unexpected

2. ☐ ILLNESS OR OTHER NATURAL CAUSE
(If applicable, complete Inadequate Care or Neglect in Section I)

1. ☐ Known Condition _____

Complete questions 2 - 11 if natural cause death in infant <1 year of age (INCLUDING SIDS)

2. Age at death?

a. ☐ 0 - 24 hours after birth
b. ☐ 24 - 48 hours
c. ☐ 48 hours - 6 weeks
d. ☐ 6 weeks - 6 months
e. ☐ 6 months - 1 year

3. Gestational age at birth?

a. ☐ <25 weeks b. ☐ 25 - 30 weeks c. ☐ 30 - 37 weeks d. ☐ >37 weeks e. ☐ Unknown

4. Birth weight in grams (approximate lbs./oz.)?

a. ☐ < 750 (<1 lb. 10 oz.)
b. ☐ 750 - 1,499 (1 lb. 10 oz. to 3 lbs. 5 oz.)
c. ☐ 1,500 - 2,499 (3 lbs. 6 oz. to 5 lbs. 5 oz.)
d. ☐ >2,500 (>5 lbs. 6 oz.)
e. ☐ Unknown

5. Multiple birth? a. ☐ Yes b. ☐ No

6. Total number of prenatal visits?

a. ☐ None b. ☐ 1 - 3 c. ☐ 4 - 6 d. ☐ 7 - 10 e. ☐ Unknown

7. First prenatal visit occurred during?

a. ☐ First trimester b. ☐ Second trimester c. ☐ Third trimester d. ☐ Unknown

8. Medical complications during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown

9. Smoking during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown

10. Drug use during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown

11. Alcohol use during pregnancy? a. ☐ Yes b. ☐ No c. ☐ Unknown

3. ☐ UNKNOWN CAUSE (Describe in narrative)

I. CIRCUMSTANCES OF DEATH

1. ☐ **SUDDEN INFANT DEATH SYNDROME** (Also complete Section H-2, questions 2-11)

1. Position of decedent at discovery?

a. ☐ On stomach, face down
b. ☐ On stomach, face to side
c. ☐ On stomach, face position unknown
d. ☐ On back
e. ☐ On side
f. ☐ Unknown

2. Normal sleeping position?

a. ☐ On Back b. ☐ On stomach c. ☐ On side d. ☐ Varies e. ☐ Unknown

3. Location of decedent when found?

a. ☐ Crib b. ☐ Playpen c. ☐ Bed d. ☐ Couch e. ☐ Floor f. ☐ Other g. ☐ Unknown

4. Was decedent sleeping alone?

a. ☐ Yes b. ☐ No c. ☐ Unknown

2. ☐ INADEQUATE CARE OR NEGLECT (Mark all that apply)

a. ☐ Apparent lack of supervision
b. ☐ Apparent lack of medical care
c. ☐ Munchausen Syndrome by Proxy
d. ☐ Failure to Thrive (non-organic)
e. ☐ Malnutrition
f. ☐ Dehydration
g. ☐ Oral water intoxication
h. ☐ Delayed medical care
i. ☐ Inadequate medical attention
j. ☐ Out-of-hospital birth
k. ☐ Other

3. ☐ VEHICLE ACCIDENT

1. Position of decedent?

a. ☐ Operator
b. ☐ Pedestrian
c. ☐ Passenger
d. ☐ Bicyclist
e. ☐ Other
f. ☐ Unknown

2. Vehicle in which decedent was occupant?

a. ☐ Car
b. ☐ Truck/RV/Van
c. ☐ Motorcycle
d. ☐ Bicycle
e. ☐ Riding mower
f. ☐ Farm tractor
g. ☐ Other farm vehicle
h. ☐ All-terrain vehicle
i. ☐ Semi/Tractor trailer unit
j. ☐ Other
k. ☐ Not applicable

3. Vehicle in which decedent was not occupant?

a. ☐ Car
b. ☐ Truck/RV/Van
c. ☐ Motorcycle
d. ☐ Bicycle
e. ☐ Riding mower
f. ☐ Farm tractor
g. ☐ Other farm vehicle
h. ☐ All-terrain vehicle
i. ☐ Semi/Tractor trailer unit
j. ☐ Other
k. ☐ Not applicable

4. Condition of road?

a. ☐ Normal b. ☐ Loose gravel c. ☐ Wet d. ☐ Ice or snow e. ☐ Other f. ☐ Unknown

5. Restraint used?

a. ☐ Present, not used
b. ☐ None in vehicle
c. ☐ Used correctly
d. ☐ Used incorrectly
e. ☐ Unknown
f. ☐ Not applicable

6. Helmet used?

a. ☐ Helmet worn
b. ☐ Helmet not worn
c. ☐ Not applicable

7. Alcohol and/or other drug use?

a. ☐ Decedent impaired
b. ☐ Driver of decedent's vehicle impaired
c. ☐ Driver of other vehicle impaired
d. ☐ Not applicable

8. Primary cause of accident?

a. ☐ Speeding
b. ☐ Carelessness
c. ☐ Mechanical failure
d. ☐ Weather conditions
e. ☐ Driver error
f. ☐ Other
g. ☐ Unknown

4. ☐ DROWNING

1. Place of drowning?

a. ☐ Lake, river, pond or creek
b. ☐ Bathtub
c. ☐ Swimming pool
d. ☐ Well/Cistern
e. ☐ Bucket
f. ☐ Wading pool
g. ☐ Other
h. ☐ Unknown

2. Activity at time of drowning?

a. ☐ Boating
b. ☐ Playing at water's edge
c. ☐ Swimming
d. ☐ Playing
e. ☐ Other
f. ☐ Unknown

3. Was decedent wearing a floatation device? a. ☐ Yes b. ☐ No

4. Did decedent enter area of water unattended? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

5. Could decedent swim? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

6. Were alcohol or drugs a factor? a. ☐ Yes b. ☐ No

MO 886-3218 (4-99)

CONTINUE ON PAGE 6

PAGE 5

5. ☐ FIREARM

1. Person handling the firearm?
   a. ☐ Decedent b ☐ Family member c. ☐ Acquaintance d. ☐ Stranger e. ☐ Unknown
2. Type of firearm?
   a. ☐ Handgun b. ☐ Rifle c. ☐ Shotgun d. ☐ Other e. ☐ Unknown
3. Age of person handling firearm? a. ☐ _____ b. ☐ Unknown
4. Use of firearm at time of injury?
   a. ☐ Shooting at other person d. ☐ Target shooting g. ☐ Playing
   b. ☐ Shooting at self e. ☐ Loading firearm h. ☐ Other
   c. ☐ Cleaning firearm f. ☐ Hunting i. ☐ Unknown
5. Did person handling firearm attend safety classes? a. ☐ Yes b. ☐ No c. ☐ Unknown

6. ☐ SUFFOCATION/STRANGULATION

1. Cause of suffocation/strangulation?
   a. ☐ Other person overlaying or rolling over decedent
   b. ☐ Wedging
   c. ☐ Food
   d. ☐ Other person's hand(s)
   e. ☐ Object covering decedent's mouth/nose
   f. ☐ Object exerting pressure on victim's neck/chest
   g. ☐ Small object or toy in mouth
   i. ☐ Other
   j. ☐ Unknown
2. If sleeping, location of decedent at the time?
   a. ☐ In crib c. ☐ In couch/chair e. ☐ In infant car seat g. ☐ Other
   b. ☐ In bed d. ☐ Being held f. ☐ On floor h. ☐ Unknown
3. If sleeping, was decedent sleeping alone?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
4. If bedding was involved:
   1. Was the design of bed hazardous?
      a. ☐ Yes b. ☐ No c. ☐ Unknown
   2. Was decedent placed on soft bedding?
      a. ☐ Yes b. ☐ No c. ☐ Unknown
   3. Was there improper use of bedding?
      a. ☐ Yes b. ☐ No c. ☐ Unknown

7. ☐ ELECTROCUTION

1. Source of electricity?
   a. ☐ Water contact c. ☐ Electrical outlet e. ☐ Tool g. ☐ Other
   b. ☐ Electrical wire d. ☐ Appliance f. ☐ Lightening h. ☐ Unknown

8. ☐ FALL INJURY

1. Fall was from?
   a. ☐ Open window c. ☐ Natural elevation e. ☐ Man-made elevation
   b. ☐ Furniture d. ☐ Stairs or steps f. ☐ Other
2. Height of fall? a. ☐ # feet _____ b. ☐ Unknown
3. Landing surface composition/hardness? a. ☐ Carpet b. ☐ Concrete c. ☐ Ground d. ☐ Other
4. Was decedent in a baby walker? a. ☐ Yes b. ☐ No c. ☐ Not applicable
5. Was decedent thrown or pushed down? a. ☐ Yes b. ☐ No c. ☐ Unknown

MO 886-3219 (4-99)

CONTINUE ON PAGE 7

PAGE 6

9. ☐ POISONING/OVERDOSE

1. Type of poisoning?

a. ☐ Prescription medicine
b. ☐ Over-the-counter medicine
c. ☐ Chemical
d. ☐ Illegal drug
e. ☐ Alcohol
f. ☐ Carbon monoxide or other gas inhalation
g. ☐ Food product
h. ☐ Other
i. ☐ Unknown

2. Was substance in safety packaging?

a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

3. Location of drug or chemical?

a. ☐ In closed, secured area b. ☐ In closed, unsecured area c. ☐ In open area

10. ☐ FIRE/BURN

1. If fire, the source?

a. ☐ Matches
b. ☐ Lighter
c. ☐ Cigarette
d. ☐ Combustibles
e. ☐ Explosives
f. ☐ Fireworks
g. ☐ Space heater
h. ☐ Faulty wiring
i. ☐ Other
j. ☐ Unknown

2. Smoke alarm present? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

3. Smoke alarm in working order? a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

4. Fire started by? a. ☐ Decedent b. ☐ Other c. ☐ No one d. ☐ Unknown

5. Activity of person starting fire?

a. ☐ Playing
b. ☐ Smoking
c. ☐ Cooking
d. ☐ Suspected arson
e. ☐ Other
f. ☐ Unknown
g. ☐ Not applicable

6. Construction of fire site?

a. ☐ Wood frame b. ☐ Brick/stone c. ☐ Metal d. ☐ Trailer e. ☐ Other f. ☐ Not applicable

7. Multiple fire injuries or deaths? a. ☐ Yes b. ☐ No

8. For structure fire, where was decedent found?

a. ☐ Hiding b. ☐ In bed c. ☐ Stairway d. ☐ Close to exit e. ☐ Other

9. Did decedent know of a fire escape plan?

a. ☐ Yes b. ☐ No c. ☐ Unknown d. ☐ Not applicable

10. If burn, the source?

a. ☐ Hot water b. ☐ Appliance c. ☐ Cigarettes d. ☐ Heater e. ☐ Chemical f. ☐ Other

11. ☐ CRUSH (Non-vehicle) (Describe in narrative)

1. Where did crush occur? a. ☐ Indoors b. ☐ Outdoors

12. ☐ CONFINEMENT

1. Place of confinement?

a. ☐ Refrigerator/Appliance
b. ☐ Motor vehicle
c. ☐ Chest/Box/Locker
d. ☐ Room/Building
e. ☐ Other

13. ☐ SHAKEN/IMPACT SYNDROME

1. Prior history of abuse?

a. ☐ Yes b. ☐ No

2. Suspected cause?

a. ☐ Crying b. ☐ Disobedience c. ☐ Feeding difficulty d. ☐ Toilet training e. ☐ Other f. ☐ Unknown

14. ☐ **OTHER INFLICTED INJURY**

1. Manner of injury?

a. ☐ Cut/stabbed b. ☐ Struck c. ☐ Thrown d. ☐ Other e. ☐ Unknown

2. Injury inflicted with?

a. ☐ Sharp object (e.g., knife, scissors) c. ☐ Hands/feet e. ☐ Unknown
b. ☐ Blunt object (e.g., hammer, bat) d. ☐ Other

15. ☐ **OTHER CAUSE** (Describe in narrative)

J. NARRATIVE DESCRIPTION OF CIRCUMSTANCES OR OTHER COMMENTS

K. SERVICES PROVIDED

1. List services provided by agencies as a result of the death. (Mark all that apply)

a. ☐ Bereavement counseling d. ☐ Emergency shelter g. ☐ Health care j. ☐ No services
b. ☐ Economic support e. ☐ Mental health services h. ☐ Legal services
c. ☐ Funeral arrangements f. ☐ Social services i. ☐ Other

L. PREVENTION

1. To what degree was this death believed to be preventable?

a. ☐ Not at all b. ☐ Possibly c. ☐ Definitely

2. Primary risk factors involved in the child's death? (Mark all that apply)

a. ☐ Medical c. ☐ Economic e. ☐ Environmental g. ☐ Drugs or alcohol
b. ☐ Social d. ☐ Behavioral f. ☐ Product safety h. ☐ Other

3. Were these risk factors identified in your community prior to the death? a. ☐ Yes b. ☐ No

4. Was any action taken in your community to address the risk factors prior to this death? a. ☐ Yes b. ☐ No

5. Could the family or child have taken actions to reduce the risk? a. ☐ Yes b. ☐ No c. ☐ Unknown

6. What prevention activities have been proposed since the death? (Mark all that apply)

a. ☐ Legislation, law or ordinance f. ☐ Consumer product safety action (800-638-8095)
b. ☐ Community safety project g. ☐ News services
c. ☐ Public forums h. ☐ Changes in agency practice
d. ☐ Educational activities in school i. ☐ Other programs or activities
e. ☐ Educational activities in the media j. ☐ None

7. Target populations for prevention activities? (Mark all that apply)

a. ☐ Children c. ☐ Parents/Care givers e. ☐ Others
b. ☐ General public d. ☐ Child protection professionals

8. Estimated costs for prevention?

a. ☐ No cost involved c. ☐ <$100 e. ☐ >$500
b. ☐ All services donated d. ☐ $100 - $500 f. ☐ Unknown

9. Lead organization?

a. ☐ Health/Medical services d. ☐ Schools g. ☐ Other
b. ☐ Social services e. ☐ Mental health services
c. ☐ Law enforcement f. ☐ Local community group

CFRP CHAIR SIGNATURE ▶	DATE (MM/DD/YY) __ __/__ __/__ __
REGIONAL COORDINATOR SIGNATURE ▶	DATE (MM/DD/YY) __ __/__ __/__ __

MO 885-3218 (4-99) PAGE 9

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LEGAL SERVICES

CHILD FATALITY REVIEW PANEL (CFRP) FINAL REPORT

TO BE COMPLETED FOR ALL REVIEWABLE CHILD DEATHS LESS THAN 18 YEARS OF AGE

INSTRUCTIONS: Complete the form with all known information and forward to the prevention coordinator within ten days.

IDENTIFICATION INFORMATION

1. DECEDENT'S NAME (FIRST, MI, LAST)

2. SEX
A. ☐ MALE B. ☐ FEMALE

3. DATE OF DEATH
__/__/__

4. DATE OF BIRTH
__/__/__

5. COUNTY OF CFRP PANEL REVIEW

6. DATE OF LAST CFRP PANEL REVIEW
__/__/__

7. CIRCUMSTANCES LEADING TO DEATH? (PRECIPITATING EVENT)

PREVENTION CONCLUSIONS

1. KEEPING IN MIND WHAT IS KNOWN ABOUT THIS TYPE OF FATALITY, IS THERE A PREVENTION MESSAGE?
A. ☐ Yes B. ☐ No

2. IF YES, WHAT PREVENTION MESSAGE(S) ARE APPROPRIATE?

3. HAVE PREVENTION INITIATIVES BEEN DISCUSSED?
A. ☐ Yes B. ☐ No

4. IF YES, WHAT TYPE OF PREVENTION INITIATIVE(S)?

A. ☐ Legislation, Law or Ordinance
B. ☐ Community Safety Project
C. ☐ Public Forums
D. ☐ Educational Activities in School
E. ☐ Educational Activities in the Media
F. ☐ Consumer Product Safety Action (800-638-8095)
G. ☐ News Service
H. ☐ Changes in Agency Practices
I. ☐ Other Programs or Activities

5. BRIEFLY DESCRIBE PREVENTION INITIATIVE(S)

6. ANTICIPATED ORGANIZATIONS INVOLVED?

A. ☐ Health/Medical Services
B. ☐ Social Services
C. ☐ Law Enforcement
D. ☐ Schools
E. ☐ Mental Health Services
F. ☐ Local Community Group
G. ☐ Other

7. TARGET POPULATIONS FOR PROPOSED PREVENTION INITIATIVE(S)?

A. ☐ Children
B. ☐ General Public
C. ☐ Parents/Caregivers
D. ☐ Child Protection Professionals
E. ☐ Other

8. IS STAT PREVENTION COORDINATOR ASSISTANCE REQUESTED CONCERNING CURRENT OR FUTURE PREVENTION INITIATIVES, E.G., FACILITATION, RESOURCES, ETC.?
A. ☐ Yes B. ☐ No

IF YES, POINT OF CONTACT: NAME/TITLE

AGENCY

MAIL/STREET ADDRESS

CITY/STATE/ZIP

PHONE

FAX

EMAIL

MO 886-0603 (10-00)

ADDITIONAL COMMENTS/CONCERNS

(Attach extra pages, as necessary)

Send completed Final Report to:

Prevention Coordinator, State Technical Assistance Team
2724 Merchants Drive, Jefferson City, MO 65109
573-751-5980 or 800-487-1626
Fax: 573-751-1479

MO 886-3883 (10-00)

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.045 Thirty-One Day Supply Maximum Restriction on Pharmacy Services Reimbursed by the Division of Medical Services. The division is adding sections (3) and (4).

PURPOSE: The purpose of this proposed amendment is to establish an exemption to the thirty-one (31) day supply maximum restriction per dispensing on pharmacy services reimbursed by the Division of Medical Services on behalf of patients eligible for any of the fee-for-service programs.

(3) All spenddown recipients are exempt from the Missouri Medicaid thirty-one (31)-day supply maximum restriction on pharmacy services.

(4) Exemptions from the thirty-one (31) day supply limitation may be given with prior authorization by the Division of Medical Services to prevent a higher level of care.

*AUTHORITY: sections 208.152, 208.153, 208.201, RSMo [1994] **2000**. Original rule filed June 29, 2000. Emergency rule filed Nov. 21, 2000, effective Dec. 1, 2000, expires May 29, 2001. Amended: Filed Dec. 5, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment is not expected to cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Office of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

PROPOSED RULE

13 CSR 70-20.050 Return of Drugs

PURPOSE: The Division of Medical Services establishes that when a pharmacy dispenses drugs in a controlled-dose delivery system, the pharmacy must give the Division of Medical Services credit for any unused portion of the drug that is reusable in accordance with applicable federal or state law.

(1) Definitions.

(A) Controlled-dose delivery system. A controlled-dose delivery system is defined as a system of dispensing of medications on behalf of a resident in a long-term care facility in manufacturer's unit dose packaging or pharmacist packager's unit-dose, unit-of-use, or strip packaging with each tablet or capsule individually wrapped, or in blister cards, all of which must be labeled according to applicable state and federal laws or regulations.

(2) Drugs dispensed in controlled-dose delivery system packaging shall be returned to the dispensing pharmacy in accordance with applicable federal or state law when the recipient no longer uses the drug. A long-term care facility must return unused drugs dispensed in controlled-dose delivery system packaging to the provider that dispensed the drugs.

(3) The Division of Medical Services shall not pay for an unused pharmacy item returned to the dispensing pharmacy by or on behalf of a Medicaid recipient, due to a change in prescription, hospitalization, death of a recipient, or other reason when the item can be accepted by the pharmacy in accordance with applicable federal or state laws or regulations. A charge is not to be made to the Division of Medical Services for the returned item.

(4) When a pharmacy dispenses drugs in a controlled-dose delivery system the pharmacy must give the Division of Medical Services credit for all reusable items (any unused portion) not taken by the Medicaid recipient. In instances in which charges have been submitted prior to the return of an item the pharmacy shall file an adjustment to notify the Division of Medical Services of the need to process a credit. The dispensing pharmacy that receives the returned drugs must repay the Division of Medical Services the amount reimbursed for drug costs from which the prescription was billed, prorated to the quantity of the drug returned. The credited amount should not include dispensing fees.

AUTHORITY: section 208.201, RSMo 2000. Original rule filed Dec. 15, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication in the **Missouri Register**. If to be hand-delivered, comments must be brought to the Office of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 20—Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.070 Computer-Generated Drug Pricing Tape and Drug Reimbursement Methodology. The division is amending sections (1) and (3).

PURPOSE: This amendment modifies the information to be obtained via the computer-generated pricing tape and modifies the basis and the method for pricing drug claims in Missouri under the Title XIX Medicaid fee-for-service program.

(1) The Division of Medical Services will obtain, by contract with a reputable medical publishing company, a weekly computer-generated tape which will provide the information needed to price all **fee-for-service** Medicaid drug claims. The tape will contain *National Drug Code* (NDC), drug name, drug strength, dosage form, package size, the Average Wholesale Price (AWP), the prices set by direct-selling manufacturers (direct prices), **Wholesaler Acquisition Cost (WAC), Required Reported Price**

(RRP), and federal Health and Human Services upper limits for specified multiple source drugs. A multiple source drug is defined as a drug marketed or sold by two (2) or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two (2) or more different proprietary names or both under a proprietary name and without that name.

(3) Reimbursement for covered drugs will be made at the lower of the—

(B) Price(s) included on the Drug Pricing File which is derived from one (1) or more of the following:

1. The AWP as furnished by the state's contracted agent, less ten and forty-three hundredths percent (10.43%);

2. The MMAC as determined by the state agency for selected multiple source drugs; *[or]*

3. Applicable federal upper limits, as *[listed in 13 CSR 70-20.071]* **found at www.dss.state.mo.us/dms** *[.];*

4. The WAC as furnished by the state's contracted agent, plus ten percent (10%); or

5. The RRP as furnished by the state's contracted agent.

AUTHORITY: sections [207.020, RSMo 1986,] 208.152, [RSMo Supp. 1990], 208.153, [RSMo Supp. 1991] and 208.201, [RSMo Supp. 1987] ***RSMo 2000****. This rule was previously as 13 CSR 40-81.150. Original rule filed April 23, 1979, effective Aug. 11, 1979. For intervening history please consult the* ***Code of State Regulations****. Amended: Filed Dec. 5, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will cost 1,235 private entities $14,866,000. The estimated cost is based on the use of wholesaler acquisition cost (WAC) values provided to the state by a nationally published drug pricing compendium. A fiscal note containing a detailed estimated cost of compliance has been filed with the secretary of state.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Office of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 13 -- Department of Social Services

Division: 70 -- Division of Medical Services

Chapter 20 -- Pharmacy Program

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 13 CSR 70-20.070 Computer-Generated Drug Pricing Tape and Drug Reimbursement Methodology

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
1235	Pharmacies	$14,866,000

III. WORKSHEET

The estimated impact of this proposed amendment is based on the use of wholesaler acquisition cost (WAC) values provided to the state by a nationally published drug pricing compendium. Annualized costs were projected from two months of pharmacy claims that were repriced using WAC plus 10% as a part of the reimbursement methodology. There are1328 pharmacies currently enrolled to participate in the Missouri Medicaid fee for service pharmacy program, of these, 1235 are actually actively participating by submitting claims for services rendered to Medicaid patients. Of the 1328 pharmacies reported above, 218 of these are small businesses with fewer than 25 employees, 216 of the 218 small pharmacies are actively participating in the program by submitting claims for services rendered to Medicaid patients. The total impact on all of these pharmacies is $14,866,000.

IV. ASSUMPTIONS

The nationally published drug pricing compendium provided WAC prices for approximately 40% of reimbursable products to provide the basis of this projection. The basis of the analysis was a repricing of all pharmacy claims that were priced using average wholesale price (AWP). Therefore the impact identified in this analysis will affect all pharmacy providers.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 91—Personal Care Program

PROPOSED AMENDMENT

13 CSR 70-91.010 Personal Care Program. The division is amending sections (3) and (5).

PURPOSE: This proposed amendment to sections (3) and (5) will reflect the change in the training requirements for personal care aides and advanced personal care aides employed by Residential Care Facility II providers who admit or continue to care for those persons who are physically capable of negotiating a normal path to safety using assistive devices or aids when necessary but are mentally incapable of negotiating such a path to safety, and who have been diagnosed with Alzheimer's disease or Alzheimer's related dementia.

(3) Criteria for Providers of Personal Care Services.

(E) For newly employed aides, the provider agency must, at a minimum, provide twenty (20) hours of orientation training.

1. In calculating these hours, the following requirements shall apply:

A. At least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment;

B. With eight (8) hours of classroom training being completed prior to client contact;

C. Twelve (12) hours of orientation may be waived with adequate documentation in the employee's records that the aide received similar training during the current or preceding state fiscal year or has been employed as an aide at an in-home or home health agency at least half-time for six (6) months or more within the current or preceding state fiscal year;

D. If an aide is a certified nurse assistant, licensed practical nurse, or registered nurse, the provider agency may waive all orientation training, except the two (2) hours' provider agency orientation, with documentation placed in the aide's personnel record. The documentation shall include the employee's license or certification number current at the time the training was waived.

2. An additional ten (10) hours of in-service training annually are required after the first twelve (12) months of employment.

3. Personal care aides employed by an RCF II are exempt from the training requirements defined in paragraphs (3)(E)1. and 2. of this rule if they have completed the training requirements described in subdivisions (9) and (10) of subsection 3 of section 198.073, RSMo Supp. 1999.

[3.] **4**. The provider agency shall have written documentation of all basic and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours and location, the date of the first client contact and shall include the aide's signature. If a provider waives any in-service training, the employee's training record shall contain supportive data for the waiver.

(5) Advanced personal care services are maintenance services provided to a recipient in the individual's home to assist with activities of daily living when this assistance requires devices and procedures related to altered body functions.

(E) Criteria for Provider of Advanced Personal Care Services. Providers of advanced personal care must meet all criteria for providers of personal care services described in section (3) of this rule. Providers must sign an addendum to their Title XIX Personal Care Provider Agreement, and must possess a valid contract with the Department of Social Services, Division of Aging to provide Title XX services including advanced personal care services. Residential care facilities wishing to provide advanced *[personel]* **personal** care services to the eligible residents of their own facility only may do so with only a signed addendum to their Title XIX Personal Care Provider Agreement.

1. All advanced personal care aides employed by the provider must be an LPN, or a certified nurse assistant; or a competency evaluated home health aide having completed both written and demonstration portions of the test required by the Missouri Department of Health and 42 CFR 484.36; or have successfully worked for the provider for a minimum of three (3) consecutive months while working at least fifteen (15) hours per week as an in-home aide that has received personal care training. In addition, advanced personal care aides may not be related to the recipient to whom they provide personal care, as defined in paragraph (3)(K)4., of this rule.

2. Personal care providers are required to provide training to advanced personal care aides, in addition to the preservice training requirements described in section (3) of this rule. The additional training shall consist of eight (8) classroom hours and must be completed prior to the provision of any advanced personal care tasks. Providers may waive this eight (8) hours of training, if the proposed advanced personal care (APC) aide is an LPN or certified nurse assistant (CNA) currently licensed or registered in the state of Missouri.

3. Advanced personal care aides employed by an RCF II are exempt from the training requirements defined in paragraphs (5)(E)1. and 2. of this rule if they have completed the training requirements described in subdivisions (9) and (10) of subsection 3 of section 198.073, RSMo Supp. 1999.

[3.] **4**. The additional advanced personal care training must include, at a minimum, the following topics:

A. Observation of the client and reporting observation;

B. Application of ointments/lotions to unbroken skin;

C. Manual assistance with oral medications;

D. Prevention of *decubiti*;

E. Bowel routines (rectal suppositories, sphincter stimulation);

F. Enemas;

G. Personal care for persons with ostomies and catheters;

H. Proper cleaning of catheter bags;

I. Positioning and support of the client;

J. Range of motion exercises;

K. Application of nonsterile dressings to superficial skin breaks; and

L. Universal precaution procedures as defined by the Center for Disease Control.

[4.] **5**. Advanced personal care tasks as specified at (5)(B)1. through 9. shall not be assigned to or performed by any advanced personal care aide who is not a licensed nurse until the aide has been fully trained to perform the task, the RN supervisor has personally observed successful execution of the task and the RN supervisor has personally certified this in the aide's personnel record. Only RN visits necessary for task observation and certification in the home may be prior authorized and billed to Medicaid as an authorized nurse visit, as described in section (6) of this rule. RN task observation and certification in a laboratory, or other non-home setting, may not be billed.

[5.] **6**. T*[H]*he RN supervisor may observe the execution of any of the tasks in a recipient's home. However, tasks specified in paragraphs (5)(B)1., 2., 3., 4., and 9. must be observed in the home, while those specified in paragraphs (5)(B)5., 6., 7., and 8. may be observed in either a home or lab setting.

[6.] **7.** For clients receiving advanced personal care services, it is required that on-site RN visits be conducted at intervals of no greater than six (6) months. During these visits, the RN must conduct and contemporaneously record and certify by his/her signature

an individualized valuation of the client's condition and the adequacy of the service plan.

*AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo [1994] **2000**. This rule was previously filed as 13 CSR 40-81.125. Original rule filed April 14, 1982, effective July 11, 1982. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment. Written comments may be mailed or delivered to the Department of Social Services, Division of Medical Services, Program Operations Unit, Christine Larsen, P.O. Box 6500, Jefferson City, MO 65102-6500. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 5—Retirement, Options, and Benefits

PROPOSED AMENDMENT

16 CSR 10-5.030 Beneficiary. The board is amending section (5).

PURPOSE: This rule sets forth the procedure for naming beneficiaries, and their eligibility as provided by sections 169.070 and 169.075, RSMo.

(5) Payments due a beneficiary of a deceased service retiree under Option 2, 3, 4, 5 or 6, shall commence with the month **following the month** in which the retiree dies. *[Reduced payments due a beneficiary of a deceased service retiree under Option 3 or Option 4 shall commence with the month following the month in which the retiree dies.]* Payments due a beneficiary under Option 2, 3, or 4 shall cease with the payment at the end of the month in which the death of the beneficiary occurs. Under Options 5 and 6, if the retiree dies prior to receiving one hundred twenty (120) or sixty (60) monthly payments, respectively, the remainder of such monthly payments shall be paid to the retiree's primary beneficiary. If the primary beneficiary dies prior to receiving the remainder of the one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the remainder of such monthly payments shall be paid to the retiree's first contingent beneficiary. If the first contingent beneficiary dies prior to receiving the remainder of one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the remainder of such monthly payments shall be paid to the retiree's second contingent beneficiary. If there is no primary or contingent beneficiary who survives the retiree for the remainder of the one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the reserve of the remainder of such payments shall be paid to the estate of the last person to receive a monthly payment.

*AUTHORITY: section 169.020, RSMo [Supp. 1998] **2000**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Public School and Non-Teacher School Employee Retirement Systems of Missouri, Joel Walters, Executive Director, P.O. Box 268, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 6—The *[Nonteacher] Non-Teacher* School Employee Retirement System of Missouri

PROPOSED AMENDMENT

16 CSR 10-6.090 Beneficiary. The board is amending section (5).

PURPOSE: This rule sets forth the procedure for paying beneficiaries under Options 2, 3, 4, 5, 6, and 7 of section 169.670, RSMo.

(5) Payments due a beneficiary of a deceased service retiree under Option 2, 3, 4, 5, *[or]*, 6**, or 7** shall commence with the month **following the month** in which the retiree dies. *[Reduced payments due a beneficiary of a deceased service retiree under Option 3 or Option 4 shall commence with the month following the month in which the retiree dies.]* Payments due a beneficiary under option 2, 3, *[or]* 4**, or 7** shall cease with the payment at the end of the month in which the death of the beneficiary occurs. Under Options 5 and 6, if the retiree dies prior to receiving one hundred twenty (120) or sixty (60) monthly payments, respectively, the remainder of such monthly payments shall be paid to the retiree's primary beneficiary. If the primary beneficiary dies prior to receiving the remainder of the one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the remainder of such monthly payments shall be paid to the retiree's first contingent beneficiary. If the first contingent beneficiary dies prior to receiving the remainder of one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the remainder of such monthly payments shall be paid to the retiree's second contingent beneficiary. If there is no primary or contingent beneficiary who survives the retiree for the remainder of the one hundred twenty (120) or sixty (60) monthly payments under Option 5 or 6, respectively, the reserve of the remainder of such payments shall be paid to the estate of the last person to receive a monthly payment.

*AUTHORITY: section 169.610, RSMo [1994] **2000**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 15, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Public School and Non-Teacher School Employee Retirement

*Systems of Missouri, Joel Walters, Executive Director, P.O. Box 268, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE
Division 10—General Administration
Chapter 1—Organization

PROPOSED AMENDMENT

20 CSR 10-1.020 Interpretation of Referenced or Adopted Material. The director is amending section (1).

PURPOSE: The purpose of this amendment is to update the materials cross-referenced in other rules of the Department of Insurance and to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(1) The versions of the following materials *[in effect on June 30, 1996]* **published as of June 30, 2000**, are incorporated by reference in the rules of the Department of Insurance under this title:

(B) National Association of Insurance Commissioners (NAIC) publications, as follows:

1. *Accounting Practices and Procedures Manual [for Property and Casualty Insurance Companies;*

2. Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies];

[3.] **2.** Annual Statement Instructions;

[4.] **3.** Valuation of Securities;

[5.] **4.** Examiner's Handbook;

[6.] **5.** NAIC Proceedings 1984, Volume I; and

[7.] **6.** NAIC uniform biographical data forms;

*AUTHORITY: section 374.045, RSMo [Supp. 1998] **2000**. Original rule filed Nov. 4, 1992, effective Aug. 9, 1993. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivision more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 200—Financial Examination
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.020 Accounting Standards and Principles. The director is amending sections (1) and (2).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(1) *[Determinations of]* **Each insurance company shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine** whether the capital stock or guarantee fund of an insurance company is impaired under section 375.560.1(1), RSMo, whether an insurance company is insolvent under section 375.560.1(2) or 375.881.1(1), RSMo, whether an insurance company is in a financial condition that its further transaction of business would be hazardous under section 375.560.1(5) or 375.881.1(3), RSMo and whether an insurance company fails to comply with the requirements for admission under section 375.881.1(2), RSMo *[shall be made]* according to the applicable accounting **guidance,** standards, **and** principles approved by the National Association of Insurance Commissioners (NAIC), *[or both,]* published in the *Accounting Practices and Procedures Manual [for Fire and Casualty Insurance Companies, Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies], Annual Statement Instructions, Valuation of Securities and Examiner's Handbook*, except where the applicable provisions of Chapters 374–385, RSMo or other specific rules expressly provide otherwise.

(2) *[Determinations of]* **Each health services corporation shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine** whether a health services corporation is maintaining the reserves required by section 354.080, RSMo and whether a health services corporation is in a condition that its further transaction of business will be hazardous under section 354.355(3), RSMo *[shall be made]* according to the applicable accounting standards or principles approved by the NAIC, or both, as published in the *Accounting Practices and Procedures Manual [for Life and Accident and Health Insurance Companies], Annual Statement Instructions, Valuation of Securities and Examiner's Handbook*, except where the applicable provisions of sections 354.010–354.380, RSMo or other specific rules expressly provide otherwise.

*AUTHORITY: sections 354.485, 354.120, [and] 354.485[, RSMo 1986] **and** 374.045, RSMo [Supp. 1993] **2000**. This rule was previously filed as 4 CSR 190-11.230. Original rule filed Feb. 3, 1989, effective May 1, 1989. Amended: Filed Aug. 25, 1989, effective Jan. 1, 1990. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 200—Financial Examination
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.040 Financial Standards for Health Maintenance Organizations. The director is amending section (2).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(2) Assets of an HMO will be admitted and included in determining the financial condition of the HMO only if included within one (1) or more of the following list of admissible assets:

(A) Investable funds under section 354.450, RSMo are as follows:

1. Any asset or investment described in and limited by sections 375.1070–375.1075, RSMo, and 376.300, 376.305 and 376.307, RSMo; and

2. Any asset or investment described in and limited by section 354.415.1(1) *[and (2)]*, RSMo. Under section 354.415.2*[.]*, RSMo, the HMO must file notice and adequate supporting information with the director for any asset or investment in excess of five hundred thousand dollars ($500,000). If the director does not disapprove the notice within sixty (60) days of the date of filing, the notice shall be deemed approved; and

(B) Other assets as follows:

1. Reinsurance recoverables pursuant to section 375.246, RSMo;

2. Data processing system pursuant to section 375.325, RSMo;

3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;

4. Accrued interest receivable**, if according to generally accepted standards of accounting for HMOs such interest is probably collectible**;

5. Inventory of medical, pharmaceutical and optical supplies**, furniture, equipment and fixtures, but only if according to generally accepted standards of accounting for HMOs such supplies, furniture, equipment and fixtures are used by the HMO in connection with the direct provision of health care services**;

[6. Prepaid malpractice insurance expense;]

[7.] **6.** Funds paid by the HMO into escrow for the purpose of purchasing or building offices or medical facilities **but only if according to generally accepted standards of accounting for HMOs such offices or facilities are** for use by the HMO **in connection with the direct provision of health care services**;

[8.] **7.** Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after September 1, 1989 will be admissible only with the prior consent of the director;

[9.] **8.** Amounts receivable from HMOs, health service corporations, insurance companies, self-insurance plans and third-party tortfeasors on account of coordination of benefits or subrogation, limited to the less of the actual amounts receivable or the amounts received during the prior year;

[10. No more than fifty percent (50%) of the depreciated value of all office furniture and equipment;] and

9. Any other asset expressly approved in writing by the director.

*AUTHORITY: section 354.485, RSMo [1994] **2000**. This rule was previously filed as 4 CSR 190-11.125. Original rule filed April 19, 1989, effective Sept. 1, 1989. Amended: Filed Sept. 15, 1992, effective June 7, 1993. Amended: Filed Nov. 23, 1998, effective July 30, 1999. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 200—Financial Examination
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.050 Financial Standards for Prepaid Dental Plans. The director is amending sections (1) and (2).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(1) Assets of a prepaid dental plan will be admitted and included in determining the financial condition of the prepaid dental plan

only if included within one (1) or more of the following list of admissible assets:

(B) Other assets shall be determined admissible assets, as follows:

1. Reinsurance recoverables;

2. Data processing system;

3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;

4. Accrued interest receivable**, if according to generally accepted standards of accounting for prepaid dental plans such interest is probably collectible**;

5. Inventory of dental supplies**, but only if according to generally accepted standards of accounting for prepaid dental plans such supplies are used by the prepaid dental plan in connection with the direct provision of dental services**;

[6. Prepaid malpractice insurance expense;]

[7.] **6.** Funds paid by the prepaid dental plan into escrow for the purpose of purchasing or building offices or facilities from which dental benefits under the plan will be performed**, but only if according to generally accepted standards of accounting for prepaid dental plans such offices or facilities are for use by the prepaid dental plan in connection with the direct provision of health care services**;

[8.] **7.** Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after April 1, 1990 will be admissible only with the prior consent of the director;

[9.] **8.** Amounts receivable on account of coordination of benefits or subrogation, limited to the actual amounts receivable or the amounts received during the prior year, whichever is less;

[10. No more than fifty percent (50%) of the depreciated value of all office furniture and equipment;] and

[11.] **9.** Any other asset expressly approved in writing by the director.

(2) No asset shall be admissible except as stated in section (1). The following list is a nonexclusive list of nonadmitted assets and no item listed may be admitted in determining the financial condition of the prepaid dental plan:

(E) Office furniture and equipment *[in excess of fifty percent (50%) of its depreciated value]*;

AUTHORITY: *section 354.723, RSMo [Supp. 1990]. This rule was previously filed as 4 CSR 190-11.280. Original rule filed Dec. 12, 1989, effective April 1, 1990. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.*

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 200—Financial Examination
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.110 Qualifications of Actuary or Consulting Actuary. The director is amending section (2).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(2) For this purpose, a **"**qualified actuary**"** shall *[be deemed to be either subsection (2)(A) or (B) as follows:*

(A) A] **mean a** member in good standing of the American Academy of Actuaries*[; or]***.**

[(B) A person who has demonstrated to the satisfaction of the director of insurance that s/he has had an educational background appropriate for the practice of actuarial science and that s/he has had extensive professional actuarial experience. To satisfy this requirement of extensive actuarial experience, a person must have had substantial actuarial responsibilities with respect to his/her employment extending over a period of time at least equal to seven (7) years of the most recent ten (10) years.]

*AUTHORITY: sections 374.045[, RSMo Supp. 1993] and 376.350, RSMo [1986] **2000**. This rule was previously filed as 4 CSR 190-11.080. Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed Aug. 16, 1977, effective Dec. 11, 1977. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.*

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the American With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 200—Financial Examination
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.140 Minimum Valuation Standards for Life, Accident and Health and Annuity Contracts. The director is amending sections (2).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(2) **Policies of Accident or Health Insurance, or Combination Policies of** Accident and Health Insurance.

(A) *[Active Life Reserves—Individual Policies.]* **On all such policies actually written there shall be maintained an unearned gross premium reserve computed according to the provisions of section 376.410(1), RSMo.**

[1. General. Active life reserves are required for all inforce policies and are in addition to any reserves required in connection with claims. For policy types A, B and C described in paragraph (2)(A)2., the minimum reserve shall be determined as specified. It should be emphasized, however, that these are minimum standards and higher, adequate reserves shall be established by the company in any case where experience indicates that the minimum standards do not place a sound value on the liabilities under the policy. For the policy described in subparagraph (2)(A)2.D., type D, the minimum reserve shall be the gross pro rata unearned premium.

2. Types of individual accident and health insurance policies.

A. Policies which are noncancellable or noncancellable and guaranteed renewable for life or to a specified age, such as sixty (60) or sixty-five (65).

B. Policies which are guaranteed renewable for life or to a specified age, such as sixty (60) or sixty-five (65), but under which the company reserves the right to change the scale of premiums.

C. Policies in which the company has reserved the right to cancel or refuse renewal for one (1) or more reasons, but has agreed, either implicitly or explicitly, that prior to a specified time or age it will not cancel or decline renewal solely because of deterioration of health after issue; however, policies shall not be considered of this type if the company has reserved the right to refuse renewal provided the right is to be exercised at the same time for all policies in the same category, unless premiums are based on the level premium principle.

D. All other individual policies except credit accident and health insurance.

3. Notes.

A. The previously mentioned does not classify franchise as a type of policy. These policies are frequently written under an agreement limiting the company's right to cancel or refuse renewal. Usually the right is reserved to refuse renewal of all policies in the group or other categories, such as those ceasing to be members of the association, and this would place those policies in type D in accordance with the last clause under subparagraph (2)(A)2.C. However, if premiums are based on the level premium principle or if the renewal privilege granted to the individual insured meets the requirements for type A, B or C, the franchise policy shall be so classified for reserve purposes.

B. A policy may have guarantees qualifying it as type A, B or C until a specified age or duration after which the guarantees, or lack of guarantees, may qualify it as type A, B, C or D. In that case, the policy in each period shall be considered for reserve purposes according to the type to which it then belongs.

C. Where all of the benefits of a policy as provided by rider or otherwise are not of the same type (A,B,C or D), each benefit shall be considered for reserve purposes according to the type to which it belongs.

4. Reserve standards for policies of type A, B or C.

A. Interest. The maximum interest rate for reserves shall be the amount specified in section 376.380, RSMo.

B. Mortality.

(I) 1941 Commissioners Standard Ordinary Table.

(II) 1958 Commissioners Standard Ordinary Table.

(III) 1941 Standard Industrial Mortality Table.

(IV) Commissioners 1961 Standard Industrial Mortality Table.

(V) Other table as may be approved by the director.

C. Morbidity or other contingency.

(I) Total disability due to accident or sickness. The minimum standard shall be the 1964 Commissioners Disability Table.

(II) Hospital expense benefits. The minimum standard shall be the 1956 Intercompany Hospital Table.

(III) Surgical expense benefits. The minimum standard shall be the 1956 Intercompany Surgical Table.

(IV) Accidental death benefits. The minimum standard shall be the 1959 Accidental Death Benefits Table.

(V) All other benefits. The company shall adopt standards to produce reserves which place a sound value on the liabilities under the benefit.

D. Negative reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy, but the mean reserve on any policy shall never be taken as less than one-half (1/2) the valuation net premium.

E. Preliminary term. For those policies which were type A, B or C when originally issued, the minimum reserve shall be on the basis of a two (2)-year preliminary term. For those policies which were of type D when originally issued, but which were subsequently changed by the company to a type A, B or C.

(I) If the change was made within two (2) years after the date of issue, the minimum reserve shall be on the basis of a two (2)-year preliminary term, measured from the date of issue.

(II) If the change was made two (2) years or more after the date of issue, the minimum reserve shall be on the net level premium basis, measured from the policy anniversary coincident with or next following the date of change.

F. Reserve method. Mean reserves diminished by appropriate credit for valuation net deferred premiums; or midterminal reserves plus gross or net pro rata unearned premium reserves. In no event, however, may the aggregate reserve for all policies be less than the gross pro rata unearned premium under those policies.

G. Alternative valuation procedures and assumptions. Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the amount determined according to the applicable standard previously specified, the company may use any reasonable assumptions as to the interest rate, mortality rates or the rates of morbidity or other contingency and may introduce an assumption as to the voluntary termination of policies. Also, subject to the preceding conditions, the company may employ methods other than the methods stated previously in determining a sound value of its liabilities under those policies including, but not limited to, the following:

(I) Optional use of either the level premium, the one (1)-year preliminary term or the two (2)-year preliminary term method;

(II) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

(III) The use of approximations, such as those involving age groupings, groupings of several years of issue or average amounts in indemnity;

(IV) The computation of the reserve for one (1) policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit(s) so valued; or

(V) The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued. For statement purposes the net reserve liability may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums, or regardless of the underlying method of calculation, it may be divided between the gross pro rata unearned premium reserve and a balancing item for the additional reserve.]

(B) *[Active Life Reserves. Group policies except credit accident and health insurance.]* **On all such policies written on a noncancellable plan and under the terms of which the company is obligated to renew or continue for a stated period, or to a stated age or for life, there shall be maintained active life reserves and reserves for losses in amounts not less than active life and loss reserves determined in accordance with the applicable minimum reserve standards prescribed by the National Association of Insurance Commissioners (NAIC) in its *Accounting Practices and Procedures Manual*.**

[1. This applies to group accident and health insurance as defined in section 376.405, RSMo.

2. The minimum reserve for active lives on all group accident and health policies shall be the pro rata gross unearned premium.

3. If a group policy contains a conversion option for terminated employees and the employees, under this provision, may receive an individual policy without evidence of insurability, the company shall establish a reserve for the morbidity cost expected in excess of these costs assumed by the premium, if any, which is then payable by or on behalf of the terminated employee. The group account shall be charged with an amount (conversion charge) to establish this reserve and after that the reserve shall be maintained as an individual policy active life reserve.]

(C) On all such policies other than those written on a noncancellable plan there shall be maintained reserves for losses in amounts not less than loss reserves determined in accordance with the applicable minimum reserve standards prescribed by the NAIC in its *Accounting Practices and Procedures Manual*.

(D) In addition to the minimum reserves mentioned in section 376.410, RSMo, and elsewhere in this section, companies shall maintain reserves for extraordinary losses in amounts not less than extraordinary loss reserves determined in accordance with the applicable minimum reserve standards prescribed by the NAIC in its *Accounting Practices and Procedures Manual*.

*[(C)]***(E)** Credit Accident and Health Insurance. All credit accident and health insurance (both individual and group) shall be established and maintained on the basis of not less than the unearned gross premium computed on the basis of the sum of digits formula, commonly known as the Rule of 78.

[(D) Claim Reserves. Present value of amounts not yet due on claims (also called disabled life reserves in the case of insurance providing loss-of-time benefits for disability due to accident or sickness).

1. General. Reserves are required for claims on all health insurance policies, group and individual of type A, B, C or D, providing benefits for continuing loss, such as loss-of-time or hospitalization.

2. Claim reserve standards for total disability due to accident or sickness.

A. Interest. The maximum interest rate for reserves shall be three and one-half percent (3 1/2%) compounded annually.

B. Morbidity. The reserve shall be established in accordance with the 1954 Commissioners Disability Table, except that for unreported claims and resisted claims and, at the option of the company, the claims with a duration of disablement of less than two (2) years, reserves may be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on those experiences or assumptions shall be verified by the development of each year's claims over a period of years.

C. For policies with an elimination period, the duration of the disablement shall be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

D. A new disability connected with a previous disability which had a duration of at least one (1) year and terminated within six (6) months of the new disability shall be considered a continuation of the previous disability.

3. Reserve standards for all other claim reserves.

A. Interest. The maximum interest rate for reserves shall be three and one-half percent (3 1/2%) compounded annually.

B. Morbidity and other contingency. The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. Results shall be verified by the development of each year's claims over a period of years.

4. Valuation procedures. The company may employ suitable approximations and estimates including, but not limited to, groupings and averages, in computing claim reserves.

(E) Policies Issued Prior to Operative Date of This Rule. Any company may elect to establish and maintain reserves as required in this rule for policies issued prior to the operative date of this rule. In making this election, a company may elect to revalue all previous issues or at its option may revalue only certain blocks of issues as determined by issue date or plan of coverage. Claim reserves may be revalued independent of active life reserves. Any election shall be made by filing written notice with the director of insurance, stating the effective date of election and identifying the reserves or issues of policies to be revalued. If no election is made, reserve standards in effect in the company prior to the operative date of this rule shall be maintained.]

(F) This section shall not apply to total and permanent disability benefits, or to accidental death benefits, contained in or supplemental to life insurance policies or other contracts and for which benefits the standard of valuation is prescribed by section 376.380, RSMo, or other sections of this or other rules of the Department of Insurance.

AUTHORITY: *section 374.045 [and], 376.380, [RSMo Supp. 1993 and] 376.390, 376.405, 376.410 and 376.670, RSMo [1986] **2000**. This rule was previously filed as 4 CSR 190-11.090. This version of rule filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed July 9, 1976, effective Feb. 20, 1977. Amended: Filed Aug. 16, 1977, effective Dec. 11, 1977. Rescinded and readopted: Filed*

May 11, 1984, effective Nov. 13, 1984. Amended: Filed Dec. 14, 2000.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE
Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance

PROPOSED AMENDMENT

20 CSR 500-10.200 Financial Regulation. The director is amending section (5).

PURPOSE: The purpose of this amendment is to make substantive and stylistic changes to make this rule as consistent as reasonably practical with the Statements of Statutory Accounting Principles (SSAP) of the National Association of Insurance Commissioners (NAIC).

(5) Reserves.

(D) Mortgage guaranty companies shall compute the unearned premium reserve on a monthly *pro rata* basis*[, except that in the case of premiums paid in advance for ten (10)-year policies the annual unearned premium factors specified in the following or comparable monthly unearned premium factors shall apply:*

Contract Year Current at Valuation Date	*Unearned Premium at Valuation Date**
1	*90.0%*
2	*70.0%*
3	*52.5%*
4	*39.0%*
5	*28.0%*
6	*19.0%*
7	*12.0%*
8	*7.0%*
9	*3.5%*
10	*1.0%*

**Includes fifty percent (50%) of the earned premium applicable to the contract year current at valuation date.*

(E) The comparable monthly unearned premium factors applicable to premium paid in advance for ten (10)-year policies, consistent with this schedule on the basis that one-twelfth (1/12) of the earned premium for each contract year is earned during each month, shall include fifty percent (50%) of the earned premium applicable to the contract month current at the valuation date.]

[(F)] **(E)** Whenever the laws of any other jurisdiction in which a mortgage guaranty company subject to the requirements of this section is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve the aggregate than that set forth, the establishment of a larger unearned premium reserve shall be in compliance with this section.

*AUTHORITY: section 374.045, RSMo [1994] **2000**. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Dec. 14, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 9:30 a.m. on February 22, 2001. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or nor heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on February 22, 2001. Written statements shall be sent to Kimberly A. Grinston, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.010 Definitions. This rule established the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effec-

tive Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

(1) When used in this plan document, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions (22 CSR 10-2.040), (22 CSR 10-2.045), (22 CSR 10-2.050), (22 CSR 10-2.055), (22 CSR 10-2.060), (22 CSR 10-2.063), (22 CSR 10-2.064), (22 CSR 10-2.065), and (22 CSR 10-2.066) as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the preferred provider organization (PPO) and co-pay plans;

(I) Co-pay plan—A set of benefits similar to the premium option. Co-payment amounts are generally an average of those for the premium and standard options;

(J) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(K) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(L) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(M) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in this plan document, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation immediately.

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the PPO plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the PPO plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning;

4. Married; or

5. Not dependent upon parents or guardian for at least fifty percent (50%) support;

(Q) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)9.;

(R) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(S) Employees—Employees of the state and other public entities and present and future retirees from state and other public entity employment who meet the eligibility requirements as prescribed by state law or other public entity who have applied and have been accepted for membership in the plan;

(T) Executive director—The administrator of the Missouri Consolidated Health Care Plan who reports directly to the plan administrator;

(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(V) Home health agency—An agency certified by the Missouri Department of Health, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(W) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(X) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(X)1. of this rule , but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Y) Lifetime—The period of time you or your eligible dependents participate in the plan;

(Z) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(AA) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(BB) Medicare HMO (risk contract)—An HMO exclusively for members residing in specified areas and covered by Medicare whereby benefits are provided in accordance with a plan approved by federal regulation;

(CC) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(DD) Open enrollment period—A period designated by the plan during which members may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(EE) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(FF) Out-of-network—Providers that do not participate in the member's health plan;

(GG) Participant—Any employee or dependent who has been accepted for membership in the plan;

(HH) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(II) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under 334.021, RSMo;

(JJ) Plan—The program of medical care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(KK) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(LL) Plan document—This statement of the terms and conditions of the plan as adopted by the plan administrator;

(MM) Plan year—Same as benefit year;

(NN) Point-of-service—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(OO) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(PP) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(QQ) Premium option—A set of covered benefits with specified co-payment and coinsurance amounts;

(RR) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(SS) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(TT) Public entity—A state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board;

(UU) Review agency—A company responsible for administration of clinical management programs;

(VV) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(WW) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(VV) of this rule which are established for the treatment of sick and injured persons

through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(XX) Staff model—A set of covered benefits established by the HMO similar to the premium and standard options, but with varying co-payment and coinsurance amounts;

(YY) Standard option—A set of covered benefits similar to the premium option, but with higher co-payment and coinsurance amounts;

(ZZ) State—Missouri;

(AAA) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. This child(ren) must rely on the parent/custodian for his/her major financial support (appropriate documentation may be required). Except for a disabled child(ren) as described in subsection (1)(GG) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-2.020(5)(D)2. for continuing coverage on handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan; and

(BBB) Usual, customary, and reasonable charge.

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.020 Membership Agreement and Participation Period. This rule established the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed March 17, 1997, effective July 1, 1997, expired Sept. 22, 1997. Amended: Filed March 17, 1997, effective Aug. 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 18, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.020 Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

(1) The application packet and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP a public entity agrees that—

1. For groups of less than five hundred (500) employees, the MCHCP will be the only health care offering made to its eligible members. For groups of five hundred (500) or more employees the entity may maintain a self-insured preferred provider organization (PPO) plan or one point-of-service (POS) option (either self-insured or on a fully-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP (also see paragraph (1)(A)8.);

2. It will contribute at least twenty-five dollars ($25) per month toward each active employee's premium;

3. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the PPO options. Appropriate proof of said deductibles will be required;

4. Eligible members joining the MCHCP who were covered by any medical plan offered by the public entity or an individual policy will not be subject to any preexisting condition;

5. Eligible members joining the MCHCP at the time of the initial eligibility of the public entity will not have to prove insurability;

6. For groups contracting only with the MCHCP, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For groups of five hundred (500) employees or more that choose one of the alternative options identified in paragraph (1)(A)1., the entity must maintain seventy-five percent (75%) coverage of all their employees covered through all of their offerings;

7. An eligible employee is one that is not covered by another group sponsored plan;

8. Public entities joining the plan must offer their eligible members all the plans available through the MCHCP;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) Effective January 1, 2001, in order to provide retiree coverage, any participating member agency joining MCHCP must have one of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

(2) The employee membership agreement shall consist of the written application of the employee, the plan document as adopted by the board and duly executed amendments. The plan booklets and any associated administrative guidelines interpret the membership agreement for the benefit of members and administrators but are not a part of the membership agreement.

(3) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan.

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event.

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided;

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is not eligible for coverage until the next open enrollment period; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan.)

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity.

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees or long-term disability recipients covered under the plan.)

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(5) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (6) and (7).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (7).

(6) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(7) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, long-term disability recipients and their dependents are not later eligible if they discontinue their coverage at some future time.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave,

may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to HMO or POS members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the rate under the regular PPO plan, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(9) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.040 Indemnity Plan Summary of Medical Benefits. This rule established the policy of the board of trustees in regard to medical benefits for participants in the Missouri Consolidated Health Care Plan Indemnity Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30,1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, terminated Feb. 18, 2000. Emergency amendment filed Feb. 8, 2000, effective Feb. 18, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.040 PPO Plan Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan PPO.

(1) Lifetime maximum, three (3) million dollars.

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5,000).

(3) Deductible Amount—Per individual for the preferral provider organization (PPO) plan each calendar year, three hundred dollars ($300), family limit each calendar year, nine hundred dollars ($900).

(4) Coinsurance.

(A) Individual:

1. PPO—Ninety percent (90%) of the first seven thousand five hundred dollars ($7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

2. Non-network—Seventy percent (70%) of the first seven thousand five hundred dollars ($7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

3. Out-of-area—Eighty percent (80%) of the first seven thousand five hundred dollars ($7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

(B) Family:

1. PPO—Ninety percent (90%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

2. Non-network—Seventy percent (70%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

3. Out-of-area—Eighty percent (80%) of the first fifteen thousand dollars ($15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

(5) The deductible will be waived and the employee or dependent will only be responsible for a ten dollar ($10) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator. Charges for other covered services provided in addition to the office visit will be covered under the regular PPO benefit(s) available at the time of service.

(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.

(7) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (7)(A) and (B) may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

(8) Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(9) Prescription Drug Program—The PPO plan provides coverage for maintenance and non-maintenance medications, as described in the following:

(A) Medications.

1. In-Network.

A. Five dollar ($5) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

2. Non-Network—The deductible will apply. After satisfaction of the deductible, claims will be paid at fifty percent (50%) coinsurance. Charges will not be applied to the out-of-pocket maximum.

3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment for a drug on the maintenance list.

(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable deductibles or coinsurance. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.045 Co-Pay Plan Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

(1) Lifetime Maximum:

(A) Network—no limit.

(B) Out-of-network, out-of-area—three (3) million dollars.

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5,000).

(3) Non-network and Out-of-Area Deductible Amount—

(A) Network—zero.

(B) Out-of-Network, Out-of-Area—three hundred dollars ($300) individual, nine hundred dollars ($900) family, per calendar year.

(4) Coinsurance.

(A) Individual—

1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the two thousand dollar ($2,000) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.

2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the four thousand five hundred dollar ($4500) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying one thousand five hundred dollar ($1,500) individual out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

(B) Family—

1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the six thousand dollar ($6,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.

2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the nine thousand dollar ($9,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying three thousand dollar ($3,000) family out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

(C) Non-Network Services—Same as subsections (4)(A) and (B) of this rule, except covered charges are reimbursed on a seventy percent (70%) basis.

(5) The employee or dependent will only be responsible for a fifteen dollar ($15) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator.

(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.

(7) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (7)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

(8) Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(9) Prescription Drug Program—The co-pay plan provides coverage for maintenance and non-maintenance medications, as described in the following:

(A) Medications.

1. In-Network.

A. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

2. Non-Network—The deductible will apply. After satisfaction of the deductible, claims will be paid at fifty percent (50%) coinsurance. Charges will not be applied to the out-of-pocket maximum.

3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment for a drug on the maintenance list.

(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable deductibles or coinsurance. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY. section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.050 Indemnity Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Indemnity Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective

July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.050 PPO Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan PPO Plan.

(1) Benefit Provisions.

(A) Subject to the provisions and limitations of this plan document and the written application of the employee, the benefits, as provided in the summary of benefits, are payable for covered charges incurred by a participant while covered for this benefit, provided the deductible requirement, if any, is met.

(B) The deductible requirement applies each calendar year to covered charges shown in the summary of benefits. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount shown in the summary of benefits.

(C) The family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement shown in the summary of benefits.

(D) The total amount of benefits payable for all covered charges incurred during an individual's lifetime shall not exceed the lifetime maximum specified in the summary of benefits, subject to reinstatement as provided in subsections (1)(E) and (F) of this rule.

(E) An annual reinstatement of benefits previously paid will be made on each January 1 for each insured person, not to exceed the automatic annual reinstatement maximum on the summary of benefits. In no event will the reinstatement increase the lifetime maximum to an amount in excess of the lifetime maximum shown in the summary of benefits.

(F) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) Only charges for those services listed in this rule which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service, and which are—a) prescribed by a doctor or provider for the therapeutic treatment of injury or sickness; b) to the extent they don't exceed any limitation; c) not excluded by the limitations; and d) for not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following: a) the medical benefits or supplies usually rendered or prescribed for the condition; and b) the usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) Covered charges are divided into mutually exclusive types and each covered charge shall be deemed to be covered on the date the medical benefit, service or supply is received.

1. Type A charges for hospital daily room and board and routine nursing. The maximum covered charge for a private room is the hospital's most common semi-private room rate unless a private room is recommended by a physician and approved by the claims administrator or the plan's medical review agency.

2. Type B charges for intensive care, concentrated care, coronary care or other special hospital unit designed to provide special care for critically ill or injured patients.

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are conducted and which are necessary for hospital admission and which are not duplicated for screening purposes upon admission to the hospital.

4. Type D special hospital charges for inpatient medical care and supplies received during any period room and board charges are made except—

A. Those included in paragraphs (2)(C)1.–3. of this rule; and

B. Special nursing care.

5. Type E charges for outpatient medical care or supplies.

6. Type F surgery and anesthesia charges of a provider for the giving of anesthesia not included in paragraphs (2)(C)4. and 5 of this rule.

7. Type G psychiatric service charges of a provider licensed to provide services which relate to care of mental conditions.

8. Type H professional service charges not included in paragraphs (2)(C)2.–7. of this rule made by a provider or by a laboratory for diagnostic laboratory and X-ray exams.

9. Type I nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on his/her own behalf.

10. Type J professional service charges of a licensed physical therapist, occupational therapist, audiologist or respiratory therapist, subject to medical necessity review by claims administrator.

11. Type K transportation charges not included in paragraphs (2)(C)3. and 4. of this rule for professional air or ground ambulance services for local transportation to and from a hospital, from a hospital to and from a local facility which provides specialized testing or treatment or from a hospital to a skilled nursing facility and charges for travel within the United States by a scheduled railroad, airline or ambulatory carrier to, but not back from, the nearest hospital equipped to furnish needed special treatment.

12. Type L charges for orthopedic or prosthetic devices and hospital-type equipment not included in paragraphs (2)(C)4. and 5. of this rule for—

A. Man-made limbs or eyes for the replacing of natural limbs or eyes;

B. Casts, splints or crutches;

C. Purchase of a truss or brace as a direct result of—

(I) An injury or sickness which began while covered under these rules; or

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair or scooter (manual or powered) or hospital equipment to aid in breathing;

E. Dialysis equipment rental, supplies, upkeep and the training of the participant or an attendant to run the equipment;

F. Colostomy bags and ureterostomy bags;

G. Bilateral hearing aids; and

H. Augmentative communication devices.

13. Type M charges for prescription drugs from a licensed pharmacist; or for anesthesia when given by a provider if not included in paragraphs (2)(C)3.–6. of this rule.

14. Type N charges for skilled nursing care including room and board when the stay is medically necessary, as determined by the claims administrator.

15. Type O charges for the services of a licensed speech therapist if the charges are made for speech therapy used for the purpose of correcting speech loss or damage which—

A. Is due to a sickness or injury, other than a functional nervous disorder or surgery due to such sickness or injury; or

B. Follows surgery to correct a birth defect.

16. Type P charges for services and supplies from a home health care agency which are medically necessary, as determined by the claims administrator.

17. Type Q charges for outpatient treatment of mental and nervous conditions.

18. Type R charges for outpatient treatment chemical dependency.

19. Type S charges for hospice services.

20. Type T charges for education and training if it will promote the patient to a lower level of medical/nursing care.

21. Type U charges for surgical and medical procedures performed by a podiatrist.

22. Type V charges for transplants.

23. Type W charges for services rendered by a physician or other provider.

24. Type X charges for normally covered services arising from a non-covered service.

25. Type Y charges for Internet Physician Visits when enrolled in the Care Support Program and registered for the service.

(D) If covered charges provide for rental of durable equipment and the participant's condition is such that use of the equipment is projected for a period of time to make purchase of the equipment less costly than rental, then with the advanced authorization by the claims administrator or his/her designee, the equipment may be purchased and the purchase price will be considered a covered charge. At the option of the claims administrator, or his/her designee, durable equipment may be purchased based on quality and cost considerations. Maintenance and repair of purchased equipment is covered if provider supplies statement of continued medical necessity in time intervals determined by claims administrator or his/her designee.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.055 Co-Pay Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

(1) Covered Charges.

(A) Allergy Injections—Fifteen dollar ($15) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered with fifty dollar ($50) co-payment if medically necessary or with prior approval. Air services covered on same basis, twenty percent (20%) coinsurance and deductible for non-emergencies.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%). Not covered out-of-network.

(D) Chiropractic Benefits—Charges subject to fifteen dollar ($15) co-payment; fifty dollar ($50) co-pay per visit maximum, two thousand dollar ($2,000) annual maximum (out-of-network only).

(E) Complications—Normally covered charges arising as a complication of a non-covered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services that are a result of that injury. Fifteen dollar ($15) office visit co-pay, regardless of where services are rendered.

(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a fifteen dollar ($15) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance, medical necessity and prior authorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and fifteen dollar ($15) co-payment for annual hearing test.

(L) Home Health Care—Covered when authorized by claims administrator.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be precertified.

(O) Hospital Benefits for Chemical Dependency—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be precertified.

(P) Hospital Room and Board—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual maximum. Must be precertified.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Not covered out-of-network. Deductible applies to out-of-area.

(S) Maternity Coverage – Fifteen dollar ($15) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Nutrient Supplement—Not covered out-of-network.

(U) Organ Transplants—The following organ transplants covered at one hundred percent (100%) through the National Transplant Program: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by the claims administrator. Donor expenses are covered. No waiting periods allowed. Non-network and out-of-area limited to maximum surgical schedule.

(V) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(W) Outpatient Mental and Nervous Disorder and Chemical Dependency—Fifteen dollar ($15) co-payment per visit.

(X) Oxygen—(Outpatient) Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(Y) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits if medically necessary.

(Z) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after fifteen dollar ($15) co-payment per office visit.

3. Internet—Covered when enrolled in the Care Support Program and registered for the service.

(AA) Plan Maximum—Not applicable for network services, out-of-network and out-of-area limited to three (3) million dollars with five thousand ($5,000) reinstatement.

(BB) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of maintenance medication for two (2) co-payments (mail order only).

(CC) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(DD) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition.

(EE) Skilled Nursing—Provided in full. Limited to one hundred and twenty (120) days.

(FF) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Fifty dollar ($50) co-payment.

AUTHORITY. section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.060 Indemnity Plan Limitations. This rule established the policy of the board of trustees in regard to limitations in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1997, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.060 PPO and Co-Pay Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan PPO Plan and Co-Pay Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) If applicable, all hospitalizations, out-patient treatment for chemical dependency or mental and nervous disorder are not pre-certified as described in 22 CSR 10-2.040(7)(A), reimbursement will be reduced by ten percent (10%) of reasonable and customary charges;

(B) Blood or plasma to the extent a refund or credit is made as a result of operation of a group blood bank or otherwise;

(C) Cosmetic, plastic, reconstructive or restorative surgery performed for the purpose of improving appearance unless such expenses are incurred for repair of a disfigurement caused from any of the following:

1. An accidental injury which was sustained while covered under these rules;

2. A sickness first manifested while covered under these rules;

3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least six (6) months; or

4. A birth defect; or

5. Mastectomies;

(D) Hearing aids once every two (2) years and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery which is performed while covered under these rules);

(E) Injury or sickness resulting from—

1. Act of war (declared or undeclared);

2. Insurrection; or

3. Atomic explosion or other release of nuclear energy under any condition except when used solely as medical treatment;

(F) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one of its agencies; or

2. Any state's cash sickness or similar law including any group insurance policy approved under such law;

(G) Medical care and supplies for which—

1. No charge is made;

2. The member or dependent is not required to pay, including but not limited to, any portion of any charges that are discounted; and

3. Charges exceed the usual, customary and reasonable rate (does not apply to network services for preferred provider organization (PPO) or co-pay plan);

(H) Injury or sickness resulting from taking part in the commission of a felony;

(I) Sickness or injury covered by Workers' Compensation, occupational disease law or similar laws, or injury if it arises out of any employment for pay, profit or gain and is covered by one of the former programs including all charges to be covered by any associated settlement agreement;

(J) Charges made with respect to a participant, but which are incurred due to the injury or sickness of a different person who is not a participant in this plan;

(K) Oral care and supplies which are used to change vertical dimension or closure, including, but not limited to:

1. Procedures used for diagnosis;

2. Procedures used for balance;

3. Restoration;

4. Fixed devices; and

5. Movable devices;

(L) Any treatment or examination of teeth or nerves connected to teeth except—

1. Extraction of bony and partial bony impactions (not covered by co-pay plan); and

2. Treatment or examination of injuries to sound and natural teeth sustained in an accident while covered under the rule, or such treatment received after the patient has been covered under the plan for at least twelve (12) consecutive months; and provided the injury/illness was incurred within one (1) year of the effective date of coverage;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following, regardless of whether or not prescribed by a physician or provider:

1. Experimental/investigational procedures, as defined in the claims administrator's guidelines;

2. Exercise for the eyes;

3. Psychological testing;

4. Nerve stimulators with the exception of transcutaneous electrical nerve stimulator (TENS) units;

5. Any treatment of obesity due solely to overeating;

6. Custodial care;

7. Gamete intrafallopian transfer/zygote intrafallopian transfer (GIFT/ZIFT);

8. Travel (see (1)(CC) of this rule), lodging (see (1)(CC) of this rule), recreation or exercise;

9. Air conditioners, purifiers or humidifiers;

10. Nonprescription drug items (except insulin and other diabetic supplies); and

11. Acupuncture, acupressure, and biofeedback;

(N) Trimming of corns, calluses and toenails unless the participant is a diabetic, has a peripheral vascular disease or is blind;

(O) Foot support unless custom-made to fit the participant's foot and prescribed by a physician;

(P) Abortion except when two (2) physicians have found and so certified in writing to the claims administrator that, on the basis of their professional judgment, the life of the mother would be endangered if the fetus were carried to term or that medical complications have arisen from a previous abortion.

1. The certification must contain a diagnosis of the disease, the clinical effect of the pregnancy on the disease with the physician's prognosis of the health of the patient as affected if the fetus were carried to term, the name and address of the patient and the names of any physicians or providers previously consulted by the patient with regard to the disease and the pregnancy;

2. At least one (1) of the two (2) physicians must also certify that s/he is not an interested physician. For purposes in this rule, an interested physician is one—

A. Whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or

B. Who is the spouse or another relative who lives with a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion;

(Q) Preexisting conditions, except charges incurred after the individual has been a participant for six (6) consecutive months. A preexisting condition is one for which medical care was received or prescribed drugs were taken, or for which expenses were incurred during the three (3) months prior to the participant's effective date. This limitation does not apply to participants transferred from another plan as provided in 22 CSR 10-2.010(1)(O)2. or 22 CSR 10-2.020(1)(A)4.;

1. Exceptions to preexisting conditions.

A. If the member had previous coverage and the break in coverage was less than sixty-three (63) days, the preexisting limitations will be reduced by the time covered under the previous plan; and

B. Preexisting limitations do not apply to:

(I) Members enrolled in a separate plan through Missouri Consolidated Health Care Plan (MCHCP) for the preceding six (6) months; or

(II) Pregnancies, newborn children, or children placed for adoption;

(R) Chemical dependency and mental and nervous disorder treatments in PPO plan are limited to:

1. Network provider.

A. First five (5) visits paid with a ten dollar ($10) co-payment;

B. Visits six (6) through ten (10) with a fifteen dollar ($15) co-payment;

C. Additional visits paid with a twenty dollar ($20) co-payment; and

D. Outpatient hospital services subject to deductible and ten percent (10%) coinsurance;

2. Non-network provider—Subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

(S) Outpatient chemical dependency and mental and nervous disorder treatments in the co-pay plan are limited to:

1. Network provider.

A. Fifteen dollar ($15) co-payment for office visits;

B. Outpatient hospital services covered at one hundred percent (100%);

2. Non-network provider—subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

(T) Marital and family counseling for group or individual psychotherapy;

(U) Chiropractic services are limited to a maximum allowable charge of fifty dollars ($50) per visit, and a two thousand dollar ($2,000) total annual maximum. Diagnostic lab and X-ray services are not included in the fifty dollar ($50) maximum per visit, but are included in the two thousand dollar ($2,000) total annual maximum. In-network office visits in the co-pay plan are subject to a fifteen dollar ($15) co-payment;

(V) Associated charges for non-covered services;

(W) Any services not specifically included as a covered benefit;

(X) Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B_{12} shots, and certain vitamin therapies as determined by the claims administrator;

(Y) Treatment of temporal mandibular joint dysfunction (TMJ) not covered unless approved by claims administrator;

(Z) Reversals of tubal ligations and vasectomies;

(AA) X-ray and office charges associated with flat feet;

(BB) Preferred Provider Organization (PPO) Office Visit Co-payments;

(CC) Transplants are limited to heart, lung, liver, kidney, cornea, bone marrow, pancreas and intestinal, and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines;

Benefits are allowed in accordance with the following schedule:

Benefit Description	The First Health National Transplant Program	First Health Network (PPO) Hospital	Non-PPO Hospital	Additional Limitations and Explanations
Plan Pays	100%	90% of NTP fees	70% of NTP fees	Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (under age 19, both parents). The plan's co-payment will be reduced by 10% when not using The First Health National Transplant Program if you do not follow the procedures required by the clinical management services program. This penalty and your non-PPO coinsurance do not apply to the out-of-pocket maximum.
Annual Deductible	NO	YES	YES	
Organ Donor Costs Per Transplant	Unlimited	$10,000	$10,000	
Travel, Lodging And Meals Allowance Per Transplant	$10,000	None	None	
Lifetime Benefit Maximum	Subject to Plan Maximum	Subject to Plan Maximum	Subject to Plan Maximum	

1. Cornea transplant covered under surgical benefit.

(DD) In addition to any other listed limitations, out-of-network services in the PPO and co-pay plans are subject to the deductible and seventy/thirty percent (70/30%) coinsurance out-of-network, eighty/twenty percent (80/20%);

(EE) Skilled nursing charges limited to one hundred twenty (120) days per calendar year;

(FF) *In vivo* artificial insemination subject to deductible (not applicable in co-pay plan) and fifty percent (50%) coinsurance, which does not apply to the out-of-pocket maximum. Not covered out-of-network;

(GG) Eye refractions limited to one annually and only if provided in the network;

(HH) Treatment of nearsightedness, farsightedness and astigmatism; and

(II) Physician Internet Visits are limited to twenty-four (24) visits per year and a $600 annual maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.063 HMO/POS/POS98 Summary of Medical Benefits. This rule established the policy of the board of trustees regarding the HMO/POS/POS98 summary of medical benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Emergency amendment filed Feb. 23, 1998, effective March 5, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Premium Plans.

(1) Covered Charges.

(A) Allergy Injections—Ten dollar ($10) co-payment for office visit also covers injection. Five dollar ($5) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to ten dollar ($10) co-payment.

2. POS—Out-of-network coverage subject to deductible and coinsurance with the same limitations as under the PPO plan.

(E) Complications—Normally covered charges arising as a complication of a noncovered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services as a result of that injury.

(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a ten dollar ($10) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance. Subject to medical necessity and authorization by HMO or POS.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and ten dollar ($10) co-payment for annual hearing test. POS out-of-network not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefits for Mental and Nervous Disorder—Provided in full with proper authorization.

(O) Hospital Benefits for Chemical Dependency—Same as for mental and nervous above.

(P) Hospital Room and Board—Provided in full. Must be arranged by HMO or POS physician.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). POS out-of-network not covered.

(S) Maternity Coverage—Ten dollar ($10) co-payment for initial visit. All other prenatal visits, delivery costs and routine postnatal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS out-of-network limited to in-network rates.

(U) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(V) Outpatient Mental and Nervous Disorder—Ten dollar ($10) co-payment per visit. Deductible and coinsurance do not apply to out-of-pocket maximum for out-of-network services. POS out-of-network limited to twenty-six (26) visits per calendar year.

(W) Oxygen (Outpatient)—Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Five dollar ($5) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits subject to medical review.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar ($10) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to three (3) million dollars with five thousand dollar ($5,000) annual reinstatement.

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Five dollar ($5) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Fifteen dollar ($15) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Twenty-five dollar ($25) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of maintenance medication for two (2) co-payments through mail order.

(BB) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(CC) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition or growth. Repair or replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired August 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.064 HMO/POS Standard Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Standard Plans.

(1) Covered Charges.

(A) Allergy Injections—Twenty dollar ($20) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to twenty dollar ($20) co-payment.

2. POS—Out-of-network services not covered.

(E) Complications—Normally covered charges arising as a complication of a noncovered service.

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restoration as a result of that injury.

(G) Durable Medical Equipment—Thirty percent (30%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a twenty dollar ($20) co-payment.

(J) Growth Hormone Therapy—Thirty percent (30%) coinsurance. Subject to medical necessity and preauthorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to thirty percent (30%) co-payment and thirty dollar ($30) co-payment for annual hearing test. POS non-network services not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization.

(O) Hospital Benefits for Chemical Dependency—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(P) Hospital Room and Board—Two hundred dollar ($200) co-payment per admission. Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Not covered.

(S) Maternity Coverage—Twenty dollar ($20) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS out-of-network not covered.

(U) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(V) Outpatient Mental and Nervous Disorder—Twenty dollar ($20) co-payment per visit. POS out-of-network services not covered.

(W) Oxygen (Outpatient)—Subject to thirty percent (30%) coinsurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits are subject to medical review.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after twenty dollar ($20) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to one (1) million dollars.

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty dollar ($30) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of maintenance medication for two (2) co-payments.

(BB) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(CC) Prosthetics—Provided in full for initial placement. Thirty percent (30%) coinsurance for coverage for repair or replacement due to change in medical condition. Repair and replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

AUTHORITY. section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.065 Staff Model Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan Staff Model.

(1) Covered Charges.

(A) Allergy Injections—Ten dollar ($10) (premium) and twenty dollar ($20) (standard) co-payment for office visit also covers injection.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%).

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) in-network—Charges subject to co-payment; ten dollars ($10) (premium), twenty dollars ($20) (standard).

(E) Dental Care—Treatment to reduce trauma as a result of accidental injury and restoration as a result of that injury. Fifty percent (50%) coinsurance. One thousand dollar ($1,000) maximum per incident.

(F) Durable Medical Equipment—Provided in full (premium); twenty percent (20%) coinsurance (standard). Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(G) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.

(H) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a ten dollar ($10) co-payment (premium); twenty dollar ($20) co-payment (standard).

(I) Hearing Aids and Testing—Covered once every three (3) years, subject to twenty percent (20%) co-payment and ten dollar ($10) co-payment for annual hearing test (premium); twenty dollar ($20) co-payment (standard).

(J) Home Health Care—Covered when authorized by HMO physician.

(K) Hospice Care—Covered in full with proper authorization.

(L) Hospital Benefit for Mental and Nervous Disorder—Covered in full (premium). Two hundred dollar ($200) co-payment per admission with six hundred dollar ($600) annual maximum (standard). Eight hundred dollar ($800) annual inpatient hospital maximum. Must have prior authorization.

(M) Hospital Benefits for Chemical Dependency—Limited to sixty (60) days annually (premium). Same as mental health, but limited to forty-five (45) days annually (standard).

(N) Hospital Room and Board—Provided in full (premium). Two hundred and fifty dollar ($250) co-payment per admission with seven hundred and fifty dollar ($750) annual inpatient hospital maximum (standard).

(O) Injections—All injections (except allergy and contraceptive injections) ten dollars ($10) (premium), twenty dollars ($20) (standard), co-payment.

(P) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) (premium). Not covered in standard plan.

(Q) Maternity Coverage—Provided in full.

(R) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO. Donor expenses are covered as long as the patient is a member of the HMO. No waiting periods allowed.

(S) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(T) Outpatient Mental and Nervous Disorder—Ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment per office visit. Ten dollar ($10) (premium), fifteen dollar ($15) (standard), co-payment for chemical dependency visits. Limited to forty (40) visits for chemical dependency per calendar year.

(U) Oxygen (Outpatient)—Provided in full.

(V) Physical Therapy and Rehabilitation Services—Ten dollar ($10) (premium), twenty dollar ($20) (standard) co-payment per visit for outpatient therapy. Limited to sixty (60) visits. Additional visits when medically necessary.

(W) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment per office visit.

(X) Plan Maximum—Not applicable.

(Y) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug. Non-formulary drugs not covered.

1. Ten dollar ($10) (premium), twenty dollars ($20) (standard), co-pay for thirty (30) day supply for generic drug on the formulary.

2. Non-formulary drugs not covered.

3. Sixty (60) day supply of maintenance medication for two dollar ($2) mailing fee and twenty dollar ($20) (premium), forty dollar ($40) (standard), co-payment.

(Z) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider. Provided in full.

(AA) Prosthetics—Covered in full (premium), twenty percent (20%) coinsurance (standard).

(BB) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—fifty dollar ($50) co-payment.

(CC) Complications—Normally covered charges arising as a complication of a noncovered service.

(DD) Growth Hormone Therapy—Subject to plan authorization and ten dollar ($10) (premium), twenty dollar ($20) (standard), co-payment.

(EE) Skilled Nursing—Covered in full and limited to 100 days annually.

(FF) Medicare HMOs (risk contracts) will provide benefits as specified in their contract and will be administered in accordance with all applicable federal statutes and regulations.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.067 HMO and POS Limitations. This rule established the policy of the board of trustees regarding the HMO and POS limitations under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amend-

ment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.067 Staff Model, HMO and POS Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan Staff Model and HMO/POS Plans.

(1) Benefits shall not be payable for, or in connection with, any medical benefit, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) Abortion services limited to situations when the life of the mother is endangered if the fetus is carried to term or due to the nonviability of the fetus;

(B) Acupuncture and biofeedback;

(C) Bone stimulators are not covered unless authorized by health maintenance organization (HMO) or point-of-service (POS);

(D) Care obtained outside the HMO or POS service area which could have been anticipated prior to leaving the service area;

(E) Care received without charge, whether or not provided at a government facility;

(F) Cosmetic or reconstructive surgery, unless medically necessary to repair a functional disorder caused by disease, injury, or congenital defect;

(G) Custodial or domiciliary care;

(H) Experimental or investigational services, procedures, supplies or drugs as defined in the HMO or POS administrative guidelines;

(I) Growth hormone therapy unless authorized by the HMO or POS;

(J) Hearing aids:

1. HMO/POS—Limited to bilateral hearing aids every two (2) years;

2. Staff Model—Limited to bilateral hearing aids every three (3) years;

(K) Hypnosis;

(L) In addition to any other listed limitations, out-of-network services in a POS are subject to the three hundred dollar ($300) deductible and seventy/thirty percent (70/30%) coinsurance (premium), sixty/forty percent (60/40%) coinsurance (standard);

(M) Injuries and illness resulting out of course of employment and covered by Worker's Compensation, occupational disease law or similar law, including all charges to be covered in any associated settlement agreement;

(N) Laetrile;

(O) Liability to provide services limited to the maximum capability of the HMO or POS in the event of major disaster, epidemic, war, riot, or other circumstances beyond the control of the HMO or POS;

(P) No coverage will be provided to the following procedures:

1. Reversal of voluntary sterilization;
2. *In vitro* fertilization;
3. Gamete intrafallopian transfer (GIFT); and
4. Zygote intrafallopian transfer (ZIFT);

(Q) Non-growth related replacement of prosthetics;

(R) Orthoptics;

(S) Out-of-network services without the proper referrals in an HMO (including staff model) are not covered services;

(T) Over-the-counter medications, except insulin;

(U) Personal comfort items;

(V) Physical examinations or immunizations requested by a third party;

(W) Physical fitness equipment;

(X) Private duty nursing unless authorized by the HMO or POS;

(Y) Services not deemed to be medically necessary;

(Z) Services not provided by an HMO contracted physician or provider unless prior approval received from the HMO;

(AA) Services not specifically included as benefits are not covered;

(BB) Services provided by family or household members;

(CC) Skilled nursing services are limited to one hundred (100) days annually (staff model), one hundred and twenty (120) days annually (HMO/POS);

(DD) Smoking cessation patches and gum;

(EE) Storage of whole blood, blood plasma, and blood products;

(FF) Transsexual surgery;

(GG) Travel and transportation expenses except those specifically listed under the covered benefits;

(HH) Treatment of military service-connected injury and illness;

(II) Treatment for obesity unless deemed medically necessary, including surgery, food supplements, behavior modification programs, and diet planning services;

(JJ) Treatment for temporal mandibular joint (TMJ) dysfunction; and

(KK) Trimming of nails, corns or calluses except for persons being treated for diabetes or peripheral vascular disease.

*AUTHORITY section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.070 Coordination of Benefits. This rule established the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;
3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. A prepayment group plan which provides medical, vision, dental or health service;
5. Government plans, including Medicare;
6. Auto insurance when permitted by the laws of the state of jurisdiction; and
7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and
2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and
2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and
2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers

that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first eighteen (18) months. Medicare is primary after the first eighteen (18) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this Proposed Rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.075 Review and Appeals procedure. This rule established the policy of the board of trustees in regard to review and appeals procedure under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS) or preferred provider organization (PPO) health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
P.O. Box 104355
Jefferson City, MO 65110

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan contractor.

3. All parties shall be notified, in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. They may cross examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required, to review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible Evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of Plans Due to Dependent Change of Address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.080 Miscellaneous Provisions. This rule established the policy of the board of trustees in regard to miscellaneous provisions for participants in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to reflect changes in the Missouri Consolidated Health Care Plan.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency rescission filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded: Filed Dec. 12, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RULE

22 CSR 10-2.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Preferred provider organization (PPO) plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's opinion, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan and claims administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register;* an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than 30 days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The 90-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 10—Missouri State Board of Accountancy
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri State Board of Accountancy under section 326.110, RSMo 2000, the board rescinds a rule as follows:

4 CSR 10-2.085 Limited Liability Companies **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2373). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 10—Missouri State Board of Accountancy
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri State Board of Accountancy under section 326.110, RSMo 2000, the board rescinds a rule as follows:

4 CSR 10-2.090 Professional Corporations **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2373). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 10—Missouri State Board of Accountancy
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri State Board of Accountancy under sections 326.021, 326.040, 326.050 and 326.110, RSMo 2000, the board adopts a rule as follows:

4 CSR 10-2.095 Ownership of CPA Firms **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2373–2374). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Embalmers and Funeral Directors under section 333.111.1, RSMo 2000, the board amends a rule as follows:

4 CSR 120-2.100 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2404–2405). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 3—Licensing of Physical Therapists and Physical Therapist Assistants

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125 and 334.550, RSMo 2000, the board amends a rule as follows:

4 CSR 150-3.010 Applicants for Licensure as Professional Physical Therapists **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2406). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 3—Licensing of Physical Therapists and Physical Therapist Assistants

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 334.125 and 334.507, RSMo 2000, the board amends a rule as follows:

4 CSR 150-3.203 Acceptable Continuing Education **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2406). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.022 and 345.030, RSMo 2000, the board amends a rule as follows:

4 CSR 150-4.056 Applicants for Provisional Licensure Renewal **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2406–2407). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015 and 345.030, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.200 Definition of Uniform Functionally Based Proficiency Evaluation **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2214). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015, 345.022 and 345.030, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.201 Supervision Requirements **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2214–2215). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Two comments were received.

COMMENT: Mary Sue Dildine submitted a letter in support of speech pathology assistants regulations.
RESPONSE: The board appreciates the comment.

COMMENT: Jeanne Hamlin, Board Member, Missouri Speech and Hearing Association (MSHA) submitted a letter opposing section (7) of the rule, stating that the rule is extremely strict by comparison of physical therapy assistants and certified occupational therapy assistants and are stricter than the American Speech and Hearing Association's (ASHA) recommendations. Ms. Hamlin stated that while she does recognize that the fields are different, assistants in other fields require minimal supervision and are considered to perform the tasks they are assigned. As a discipline coordinator, Ms. Hamlin, is concerned that she will not have the ability to utilize an assistant efficiently with patients that are appropriate for their skill level to treat if they need an extreme level of direct supervision. The expectations of productivity in our hospital systems need the ability to delegate tasks that do not need the skills of a speech language pathologist. If 30% of a staff member's time is

needed to directly supervise the assistant, they will not be able to complete evaluations and treatments of a higher skill level that are needed. A 10% supervision level after the first 1–3 months of work would seem more reasonable. Patients are individuals and so are their needs. Ms. Hamlin suggested that the speech language pathologist should be able to determine the level of supervision needed, which should vary depending on the level of skill needed and individual patient issues. Ms. Hamlin questioned whether the intent is that the assistant only have one supervisor or if they can have a primary supervisor but have more than one speech language pathologist delegate treatment to them. Ms. Hamlin stated that the intent of including the assistant in the licensure laws was for the purpose of assuring an appropriate scope of practice and appropriate, not unreasonable, supervision in order to utilize different skill levels in the field for efficiency and to remain a viable service. Ms. Hamlin concluded her comments by stating that speech language pathologists are responsible for the treatment delegated and should determine the amount of supervision on experience and need, not a percent per patient that cannot be realistically met or is needed.
RESPONSE: The Board reviewed Ms. Hamlin's comments and determined that Ms. Hamlin's concerns were already addressed in Rule 4 CSR 150-4.201(7), therefore, no changes were made to the text of the proposed rule.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015 and 345.030, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.203 Scope of Practice **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2215–2216). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: One comment was received.

COMMENT: Sallie-Shaindy P. Lowenthal submitted a comment opposing speech-language pathology assistants being permitted to conduct speech-language and hearing screening without interpretation. Ms. Lowenthal stated that only trained speech and language pathologists should be performing screenings or evaluations as one must have a thorough understanding of normal speech and language behaviors before attempting to screen and even informally refer a child for further testing or determine that a child's performance does not warrant further attention. Ms. Lowenthal also stated that is it not in the best interest of any child to be screened by one individual and have a second individual interpret that screening as indicated in section (4) of the rule. Such screenings could cause children to fall through the cracks since their language difficulties went undetected by the screener. Often times those screenings cost parents significant time and money in evaluations when their child is found to have a problem that a properly trained speech and language pathologist would not have found to be problematic. Ms. Lowenthal stated that she believes it is in the best interest of the community to be treated by properly trained and licensed speech language pathologists and audiologists. However, since assistants are now a reality and cannot be avoided, we must at least make sure that they are properly supervised and that their scope of practice be limited so that clients can only be affected positively.
RESPONSE: The Board reviewed this comment and determined that this issue is addressed by statute.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015 and 345.030, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.205 Procedural Process for Registration **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2216–2220). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015, 345.030, and 345.065, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.210 Display of Certificate **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2221). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 150—State Board of Registration for the Healing Arts
Chapter 4—Licensing of Speech-Language Pathologists and Audiologists

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under sections 345.015, 345.030, and 345.051, RSMo 2000, the board adopts a rule as follows:

4 CSR 150-4.215 Renewal of Certificate of Registration **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2221–2224). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 205—Missouri Board of Occupational Therapy
Chapter 4—Supervision

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Occupational Therapy under sections 324.050, 324.056, 324.065, 324.083, and 324.086, RSMo 2000, the board amends a rule as follows:

4 CSR 205-4.030 Supervision of Occupational Therapy Aides **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2407–2408). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 70—Special Education
Chapter 742—Special Education

ORDER OF RULEMAKING

By the authority vested in the state board of education under section 178.430, RSMo 2000, the board hereby amends a rule as follows:

5 CSR 70-742.141 is amended.

A notice of proposed rulemaking was not published because state program plans required under federal education acts or regulations are specifically exempt under section 536.021, RSMo. Public hearings were held on June 9, 2000 in Springfield; June 13, 2000 in Kansas City; and June 15, 2000 in St. Louis. Comments received were considered prior to submitting the application to the United States Department of Education.

This proposed amendment becomes effective thirty days after publication in the C*ode of State Regulations*. This rule describes Missouri's services for infants and toddlers with disabilities, in accordance with Part C of the Individuals with Disabilities Education Act, Public Law 105-17.

5 CSR 70-742.141 Individuals with Disabilities Education Act, Public Law 105-17, Part C. This amendment of incorporated by reference material is needed to bring the program plan in compliance with federal statutes.

PURPOSE: The Department of Elementary and Secondary Education is eligible to apply for and receive federal funds under the Individuals with Disabilities Education Act of 1986 for the provision of early intervention services to infants and toddlers with disabilities. This rule incorporates by reference changes to the annual program plan required by new federal statutes for the provision of the services to eligible children.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

*AUTHORITY: section 178.430, RSMo [1994] **2000**, Executive Order 94-22 of the Governor, Public Law 105-17, Individuals with Disabilities Education Act. Original rule filed Dec. 29, 1997, effective March 30, 1998. Amended: Filed July 31, 1998, effective Oct. 30, 1998. Amended: Filed Dec. 7, 2000.*

PUBLIC COST: This order of rulemaking will cost state agencies or political subdivisions $18,575,648 in the aggregate assuming the life of the rule is for two fiscal years based on the one-year extension by the federal government to submit a new State Plan.

FISCAL NOTE
PUBLIC ENTITY COST

1. Rule Number

Title: Department of Elementary and Secondary Education

Division: 70 Special Education

Chapter: 742 Special Education

Type of Rulemaking: Order of Rulemaking

Rule Number and Name: 5 CSR 70-742.141 Individuals with Disabilities Education Act, Public Law 105-17, Part C

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Elementary & Secondary Education	$2,267,839
Department of Health	$4,191,868
Department of Mental Health	$8,915,941
Department of Social Services	$3,200,000

III. WORKSHEET

Cost estimates are based upon FY98 end of fiscal year data provided by collaborating state agencies. Funds represented here support early intervention services, training, technical assistance, and administrative costs for the First Steps system. Approximate total costs for all agencies affected: $ 18,575,648

IV. ASSUMPTIONS

Costs presented are based upon FY00 end of year data. Costs are projected to rise during the two year period of implementation of the order of rulemaking due to increases in number of services provided and anticipated number of children and families served.

Sources of revenue for early intervention system as of July 1,2000:

Part C Federal Grant Award	$6,715,166
General Revenue (DESE)	$2,267,839
General Revenue (DOH)	$ 40,000
General Revenue (DMH)	$1,243,421
General Revenue (DOSS)	$1,312,050 (state match for federal Medicaid dollars)
Medicaid (Federal only) (DOSS)	$1,968,075
Total	$13,546,551

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 701.355, RSMo 2000, the department amends a rule as follows:

11 CSR 40-5.040 Registration **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2411). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 701.355, RSMo 2000, the department amends a rule as follows:

11 CSR 40-5.050 New Installations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2411). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 701.355, RSMo 2000, the department amends a rule as follows:

11 CSR 40-5.065 Missouri Minimum Safety Codes for Existing Elevator Equipment **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2411). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 701.355, RSMo 2000, the department amends a rule as follows:

11 CSR 40-5.090 Inspection and Testing **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2412). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 5—Elevators

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under section 701.355, RSMo 2000, the department amends a rule as follows:

11 CSR 40-5.120 Inspectors **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2412–2414). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.270, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-3.131 Change of State Sales Tax Rate **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2414). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.270, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-3.210 Seller Must Charge Correct Rate **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2414). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.705, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-4.624 Change of State Use Tax Rate **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2414). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 25—Motor Vehicle Financial Responsibility

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 303.290, RSMo 2000, the director amends a rule as follows:

12 CSR 10-25.050 Filing a Report of an Accident with the Director of Revenue **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2415–2419). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 25—Motor Vehicle Financial Responsibility

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 303.290, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-25.130 Proof of Financial Responsibility for Reinstatement of Failure to Show Proof of Financial Responsibility Suspensions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2420). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 25—Motor Vehicle Financial Responsibility

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 303.290, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-25.140 Financial Responsibility—Inoperable/Stored Vehicles **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2420). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 25—Motor Vehicle Financial Responsibility

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 303.290, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-25.150 Financial Responsibility Sampling **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2420–2421). No changes have been made in the text of this proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 103—Sales/Use Tax—Imposition of Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.270, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-103.555 Determining Taxable Gross Receipts **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2421–2422). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 103—Sales/Use Tax—Imposition of Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.270, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-103.800 Tax Computation **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2422–2423). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 30—State Tax Commission
Chapter 3—Local Assessment of Property and Appeals from Local Boards of Equalization

ORDER OF RULEMAKING

By the authority vested in the State Tax Commission under sections 137.1018 and 137.1021, RSMo 2000, the commission amends a rule as follows:

12 CSR 30-3.025 Collateral Estoppel **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 1, 2000 (25 MoReg 2242–2243). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received by the State Tax Commission during the comment period.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 19—Energy Assistance

ORDER OF RULEMAKING

By the authority vested in the director of the Division of Family Services under section 207.020, RSMo 2000, the director amends a rule as follows:

13 CSR 40-19.020 Low Income Home Energy Assistance Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2439–2441). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Division of Family Services
Chapter 91—Rehabilitation Services for the Blind

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Social Services, Division of Family Services under sections 207.010, 207.020, 209.010 and 209.020, RSMo 2000, the division hereby amends a rule as follows:

13 CSR 40-91.030 Prevention of Blindness Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 15, 2000 (25 MoReg 2309–2311). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments received.

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 3—Rules Applying to Political Subdivisions

ORDER OF RULEMAKING

By the authority vested in the Missouri State Auditor under section 137.073, RSMo 2000, the state auditor rescinds a rule as follows:

15 CSR 40-3.100 Revision of Property Tax Rates by School Districts **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 15, 2000 (25 MoReg 2103–2104). No changes have been made in the proposed rescission, therefore it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 3—Rules Applying to Political Subdivisions

ORDER OF RULEMAKING

By the authority vested in the Missouri State Auditor under section 137.073, RSMo 2000, the state auditor rescinds a rule as follows:

15 CSR 40-3.110 Revision of Property Tax Rates by Political Subdivisions Other Than School Districts **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 15, 2000 (25 MoReg 2104). No changes have been made in the proposed rescission, therefore it is not reprinted here. This proposed rescission becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 3—Rules Applying to Political Subdivisions

ORDER OF RULEMAKING

By the authority vested in the Missouri State Auditor under section 137.073, RSMo 2000, the state auditor adopts a rule as follows:

15 CSR 40-3.120 Calculation and Revision of Property Tax Rates **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 15, 2000 (25 MoReg 2104). No changes have been made in the text of the proposed rule, therefore it is not reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 4—Membership and Creditable Service

ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.020, RSMo 2000, the board hereby amends a rule as follows:

16 CSR 10-4.014 Reinstatement and Credit Purchases **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2442–2443). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 5—Retirement, Options, and Benefits

ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.020, RSMo 2000, the board hereby amends a rule as follows:

16 CSR 10-5.055 Cost-of-Living Adjustments **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2443). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 6—The Non-Teacher School Employee Retirement System of Missouri

ORDER OF RULEMAKING

By the authority vested in the board of trustees under section 169.610, RSMo 2000, the board hereby amends a rule as follows:

16 CSR 10-6.060 Service Retirement **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2443–2445). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

ORDER OF RULEMAKING

By the authority vested in the Board of Trustees of the Missouri Local Government Employees' Retirement System under section 70.605.21, RSMo 2000, the board hereby amends a rule as follows:

16 CSR 20-2.060 Correction of Errors **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2445). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 3—Hearings and Proceedings

ORDER OF RULEMAKING

By the authority vested in the Board of Trustees of the Missouri Local Government Employees' Retirement System under section 70.605.21, RSMo 2000, the board hereby amends a rule as follows:

16 CSR 20-3.010 Hearings and Proceedings **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 2, 2000 (25 MoReg 2445). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH
Division 10—Office of the Director
Chapter 4—Coordinated Health Care Services

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Health under section 191.411, RSMo 2000, the director amends a rule as follows:

19 CSR 10-4.020 J-1 Visa Waiver Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 16, 2000 (25 MoReg 2552–2554). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs and other items required to be published in the *Missouri Register* by law.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 100—Division of Credit Unions

APPLICATIONS FOR NEW GROUPS OR GEOGRAPHIC AREAS

Pursuant to section 370.081(4), RSMo 2000, the Director of the Missouri Division of Credit Unions is required to cause notice to be published that the following credit unions have submitted applications to add new groups or geographic areas to their membership.

Credit Union	Proposed New Group or Geographic Area
Mazuma Credit Union 9300 Troost Kansas City, MO 64131	Clay County Platte County Jackson County

NOTICE TO SUBMIT COMMENTS: Anyone may file a written statement in support of or in opposition to any of these applications. Comments shall be filed with: Director, Division of Credit Unions, P.O. Box 1607, Jefferson City, MO 65102. To be considered, written comments must be submitted no later than ten business days after publication of this notice in the ***Missouri Register****.*

Title 19—DEPARTMENT OF HEALTH
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. Decisions are tentatively scheduled for the January 22, 2001 Certificate of Need meeting. These applications are available for public inspection at the address shown below.

DATE FILED:
APPLICATION PROJECT NO. &
NAME/COST & DESCRIPTION/
CITY & COUNTY

12/05/00

#3055 NP: Crawford Ranch Boarding Home, 2200 Var Vera Road, Doe Run 63637 (St. Francois County), $130,000 Long-term care (LTC) bed expansion of 10 residential care facility (RCF) beds through purchase from Riverview Gardens Retirement Village, 1040 Hwy. H. Farmington 63640 (St. Francois County)

12/08/00

#3065 RS: Kirksville Residential Care Center No. 2, Lot 3, Burkhart Subdivision, Kirksville 63501 (Adair County), $975,000, Replace 19 RCF beds located at Kirksville Residential Care Facility, 2204 S. Halliburton St., Kirksville 63501 (Adair County)

#3068 NS: Compton Heights Skilled Nursing Facility, 2507 Lemay Ferry Road, St. Louis 63125 (St. Louis County) $7,538,000, Replace Compton Heights, a 96-bed skilled nursing facility (SNF) located at 3545 Lafayette Ave., St. Louis 63104 (St. Louis County)

12/12/00

#3070 RS: Deutsch Family Investments, LLC, Three McKnight Place, St. Louis 63124 (St. Louis County), $6,000,000, Replace Walnut Grove Manor, a 25-bed RCF located at 9732 Natural Bridge Road, Berkeley 63134 (St. Louis County)

#3069 NS: New Mark Care Center, 11221 North Nashua Drive, Kansas City (Jackson County) $702,440, Replace Gladstone Nursing Home, a 21-bed ICF and 7-bed RCF located at 435 Gladstone Blvd., Kansas City 64124 (Jackson County)

#2996 NP: South Hampton Place, 4700 Branden Woods, Columbia 65203 (Boone County), $241,000, LTC bed expansion of 34 SNF beds through purchase from Cleveland Care Center, 7001 Cleveland, Kansas City 64132 (Jackson County)

Any person wishing to request a public hearing for the purpose of commenting on any of these applications must submit a written request to this effect, which must be received at the address listed below by January 11, 2001. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
915 G Leslie Boulevard
Jefferson City, MO 65101

For additional information contact:
Donna Schuessler, 573-751-6403.

OFFICE OF ADMINISTRATION
Division of Purchasing

BID OPENINGS

Sealed Bids in one (1) copy will be received by the Division of Purchasing, Room 580, Truman Building, P.O. Box 809, Jefferson City, MO 65102, telephone (573) 751-2387 at 2:00 p.m. on dates specified below for various agencies throughout Missouri. Bids are available to download via our homepage: http://www.state.mo.us/oa/purch/purch.htm. Prospective bidders may receive specifications upon request.

B1E01205 Gas Chromatograph 1/16/01;
B3Z01113 Conference Services-Training Site: Kansas City Area 1/16/01;
B1E01224 Thermal Transfer Ribbon 1/17/01;
B1E01226 Grounds Care Equipment 1/17/01;
B1E01233 Vinyl, Acetate, Foil 1/17/01;
B2Z01024 Vision: Clear Access Software & Maintenance 1/17/01;
B3Z01121 Physical Fitness and Exercise Program 1/17/01;
B1E01001 Food Service Products 1/18/01;
B1E01199 Outboard Motors 1/18/01;
B1E01225 Lift: Articulating Boom 1/18/01;
B1E01227 Truck, Single Axle 1/18/01;
B3E01126 Janitorial Services 1/18/01;
B3E01130 Uniform Rental Services-Fulton State Hospital 1/19/01;
B1E01208 Truck: Single Axle 1/23/01;
B1E01213 Utility Body: Aerial Device 1/23/01;
B1E01221 Subscription: Microfilm 1/23/01;
B1E01231 Attachment: Tree Spade 1/23/01;
B1E01242 Dairy Products: Cheese 1/24/01;
B1E01238 Bakery Products-Marshall 1/25/01;
B1E01241 Printing Plates-ENCO 1/26/01;
B3Z01128 Newsletter for Foster/Adoptive Parents 1/29/01;
B1E01228 Backhoe/Loader 1/30/01;
B2Z01022 Lottery Scratcher Ticket Games/Services 1/30/01;
B3Z01094 Environmental Assessment Services 2/5/01.

It is the intent of the State of Missouri, Division of Purchasing to purchase the following as a single feasible source without competitive bids. If suppliers exist other than the one identified, contact (573) 751-2387 immediately.

Support Partner Program, supplied by the Brain Injury Association of Missouri.

Proprietary Dye Lot Fabrics and Leathers, supplied by Unika Vaev, Garrett Leather, Maharem, Hickory Chair, and Spinneybeck. (For attachment, please call (573) 751-1683).

Joyce Murphy, CPPO,
Director of Purchasing

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—24 (1999), 25 (2000) and 26 (2001). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable and RUC indicates a rule under consideration.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				23 MoReg 2473 24 MoReg 2535 25 MoReg 2478
1 CSR 10-15.010	Commission of Administration		This Issue		
1 CSR 20-5.010	Personnel Advisory Board and Division of Personnel		25 MoReg 2872		
1 CSR 20-5.020	Personnel Advisory Board and Division of Personnel		25 MoReg 2872		
1 CSR 20-6.010	Personnel Advisory Board and Division of Personnel		25 MoReg 2873		
	DEPARTMENT OF AGRICULTURE				
2 CSR 10-5.005	Market Development	24 MoReg 2269			
2 CSR 30-10.010	Animal Health	26 MoReg 5	25 MoReg 2515		
2 CSR 70-13.030	Plant Industries		25 MoReg 2370		
2 CSR 90-21.060	Weights and Measures		25 MoReg 2788		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-7.455	Conservation Commission		25 MoReg 2214 N.A.	25 MoReg 2735 26 MoReg 60	 26 MoReg 75
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 10-2.085	Missouri State Board of Accountancy		25 MoReg 2373R	This IssueR	
4 CSR 10-2.090	Missouri State Board of Accountancy		25 MoReg 2373R	This IssueR	
4 CSR 10-2.095	Missouri State Board of Accountancy		25 MoReg 2373	This Issue	
4 CSR 15-1.010	Acupuncturist Advisory Committee		25 MoReg 2374		
4 CSR 15-1.020	Acupuncturist Advisory Committee		25 MoReg 2375		
4 CSR 15-1.030	Acupuncturist Advisory Committee		25 MoReg 2375		
4 CSR 15-1.040	Acupuncturist Advisory Committee		25 MoReg 2379		
4 CSR 15-2.010	Acupuncturist Advisory Committee		25 MoReg 2379		
4 CSR 15-2.020	Acupuncturist Advisory Committee		25 MoReg 2384		
4 CSR 15-2.030	Acupuncturist Advisory Committee		25 MoReg 2388		
4 CSR 15-2.040	Acupuncturist Advisory Committee		25 MoReg 2392		
4 CSR 15-3.010	Acupuncturist Advisory Committee		25 MoReg 2392		
4 CSR 15-3.020	Acupuncturist Advisory Committee		25 MoReg 2395		
4 CSR 15-3.030	Acupuncturist Advisory Committee		25 MoReg 2395		
4 CSR 15-4.010	Acupuncturist Advisory Committee		25 MoReg 2396		
4 CSR 15-4.020	Acupuncturist Advisory Committee		25 MoReg 2397		
4 CSR 15-5.010	Acupuncturist Advisory Committee		25 MoReg 2397		
4 CSR 15-5.020	Acupuncturist Advisory Committee		25 MoReg 2401		
4 CSR 30-6.015	Architects, Professional Engineers and Professional Land Surveyors		26 MoReg 12		
4 CSR 30-6.020	Architects, Professional Engineers and Professional Land Surveyors		26 MoReg 17		
4 CSR 40-1.021	Office of Athletics	21 MoReg 2680			
4 CSR 40-5.070	Office of Athletics	21 MoReg 1963			
4 CSR 60-1.025	State Board of Barber Examiners		26 MoReg 20		
4 CSR 60-1.030	State Board of Barber Examiners		26 MoReg 22		
4 CSR 60-4.015	State Board of Barber Examiners		26 MoReg 24		
4 CSR 90-4.010	State Board of Cosmetology		25 MoReg 2048	25 MoReg 2833	
4 CSR 90-13.010	State Board of Cosmetology		26 MoReg 24		
4 CSR 100	Division of Credit Unions				25 MoReg 2253 25 MoReg 2335 25 MoReg 2477 25 MoReg 2685 25 MoReg 2745 25 MoReg 2914 25 MoReg 2914 This Issue
4 CSR 100-2.045	Division of Credit Unions		25 MoReg 2877		
4 CSR 100-2.185	Division of Credit Unions		This Issue		
4 CSR 100-2.220	Division of Credit Unions		This Issue		
4 CSR 120-1.100	Board of Embalmers and Funeral Directors		25 MoReg 2404		
4 CSR 120-2.100	Board of Embalmers and Funeral Directors			This Issue	
4 CSR 145-2.055	Missouri Board of Geologist Registration		25 MoReg 2049	25 MoReg 2833	
4 CSR 145-2.060	Missouri Board of Geologist Registration		25 MoReg 2053	25 MoReg 2833	
4 CSR 145-2.070	Missouri Board of Geologist Registration		25 MoReg 2053	25 MoReg 2833	
4 CSR 150-3.010	State Board of Registration for the Healing Arts		25 MoReg 2406	This Issue	
4 CSR 150-3.060	State Board of Registration for the Healing Arts		25 MoReg 2515		
4 CSR 150-3.080	State Board of Registration for the Healing Arts		25 MoReg 2516		
4 CSR 150-3.170	State Board of Registration for the Healing Arts		25 MoReg 2518		
4 CSR 150-3.203	State Board of Registration for the Healing Arts		25 MoReg 2406	This Issue	
4 CSR 150-4.056	State Board of Registration for the Healing Arts		25 MoReg 2406	This Issue	
4 CSR 150-4.200	State Board of Registration for the Healing Arts		25 MoReg 2214	This Issue	
4 CSR 150-4.201	State Board of Registration for the Healing Arts		25 MoReg 2215	This Issue	
4 CSR 150-4.203	State Board of Registration for the Healing Arts		25 MoReg 2215	This Issue	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 150-4.205	State Board of Registration for the Healing Arts		25 MoReg 2216	This Issue	
4 CSR 150-4.210	State Board of Registration for the Healing Arts		25 MoReg 2221	This Issue	
4 CSR 150-4.215	State Board of Registration for the Healing Arts		25 MoReg 2221	This Issue	
4 CSR 200-2.001	State Board of Nursing		26 MoReg 27		
4 CSR 200-2.010	State Board of Nursing		26 MoReg 28		
4 CSR 200-2.020	State Board of Nursing		26 MoReg 29		
4 CSR 200-2.030	State Board of Nursing		26 MoReg 30		
4 CSR 200-2.050	State Board of Nursing		26 MoReg 30		
4 CSR 200-2.110	State Board of Nursing		26 MoReg 30		
4 CSR 200-2.120	State Board of Nursing		26 MoReg 30		
4 CSR 200-2.180	State Board of Nursing		26 MoReg 31		
4 CSR 200-3.001	State Board of Nursing		26 MoReg 31		
4 CSR 200-3.010	State Board of Nursing		26 MoReg 33		
4 CSR 200-3.020	State Board of Nursing		26 MoReg 34		
4 CSR 200-3.030	State Board of Nursing		26 MoReg 34		
4 CSR 200-3.050	State Board of Nursing		26 MoReg 34		
4 CSR 200-3.110	State Board of Nursing		26 MoReg 34		
4 CSR 200-3.120	State Board of Nursing		26 MoReg 35		
4 CSR 200-3.180	State Board of Nursing		26 MoReg 35		
4 CSR 200-4.010	State Board of Nursing	This Issue	This Issue		
4 CSR 200-4.040	State Board of Nursing		25 MoReg 2090		25 MoReg 2834
4 CSR 205-4.030	Missouri Board of Occupational Therapy		25 MoReg 2407	This Issue	
4 CSR 210-2.060	State Board of Optometry		22 MoReg 1443		
4 CSR 220-2.018	State Board of Pharmacy		25 MoReg 2789		
4 CSR 220-2.030	State Board of Pharmacy		25 MoReg 2789		
4 CSR 220-2.080	State Board of Pharmacy		25 MoReg 2790		
4 CSR 220-2.085	State Board of Pharmacy		25 MoReg 2225		25 MoReg 2907
4 CSR 220-2.090	State Board of Pharmacy		25 MoReg 2791		
4 CSR 220-2.120	State Board of Pharmacy		25 MoReg 2225		25 MoReg 2907
4 CSR 220-2.130	State Board of Pharmacy		25 MoReg 2225		25 MoReg 2907
4 CSR 220-2.140	State Board of Pharmacy		25 MoReg 2226		25 MoReg 2907
4 CSR 220-2.300	State Board of Pharmacy		25 MoReg 2791R 25 MoReg 2791		
4 CSR 220-2.900	State Board of Pharmacy		25 MoReg 2792		
4 CSR 220-5.020	State Board of Pharmacy		25 MoReg 2795		
4 CSR 220-5.030	State Board of Pharmacy		25 MoReg 2795		
4 CSR 232-1.040	Missouri State Committee of Interpreters		26 MoReg 35		
4 CSR 232-3.010	Missouri State Committee of Interpreters		26 MoReg 39		
4 CSR 240-40.020	Public Service Commission		This Issue		
4 CSR 240-40.030	Public Service Commission		This Issue		
4 CSR 240-120.130	Public Service Commission		25 MoReg 2520		
4 CSR 240-120.135	Public Service Commission		25 MoReg 2520		
4 CSR 240-121.180	Public Service Commission		25 MoReg 2523		
4 CSR 240-121.185	Public Service Commission		25 MoReg 2523		
4 CSR 240-123.075	Public Service Commission		25 MoReg 2526		
4 CSR 265-10.030	Division of Motor Carrier and Railroad Safety	This Issue	This Issue		
4 CSR 270-2.031	Missouri Veterinary Medical Board		25 MoReg 2227		25 MoReg 2908
4 CSR 270-2.041	Missouri Veterinary Medical Board		25 MoReg 2229		25 MoReg 2908
4 CSR 270-2.060	Missouri Veterinary Medical Board		25 MoReg 2231		25 MoReg 2908
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 30-4.020	Division of School Services		25 MoReg 2090R		26 MoReg 60R
5 CSR 30-261.010	Division of School Services		25 MoReg 2632		
5 CSR 30-345.011	Division of School Services		25 MoReg 2633		
5 CSR 50-270.010	Division of Instruction		25 MoReg 2231		26 MoReg 60
5 CSR 50-350.040	Division of Instruction *(Changed from 5 CSR 60-120.060)*		25 MoReg 2636		
5 CSR 50-378.100	Division of Instruction		25 MoReg 2633		
5 CSR 60-120.060	Vocational and Adult Education *(Changed to 5 CSR 50-350.040)*		25 MoReg 2636		
5 CSR 60-120.070	Vocational and Adult Education		25 MoReg 2090		26 MoReg 61
5 CSR 60-120.080	Vocational and Adult Education		This Issue		
5 CSR 60-480.100	Vocational and Adult Education		25 MoReg 2091		26 MoReg 61
5 CSR 60-900.050	Vocational and Adult Education		25 MoReg 2093		26 MoReg 61
5 CSR 70-742.141	Special Education		N.A.		This Issue
5 CSR 70-742.170	Special Education		25 MoReg 2234		26 MoReg 62
5 CSR 80-805.015	Urban and Teacher Education		25 MoReg 2234		26 MoReg 62
5 CSR 80-805.016	Urban and Teacher Education		25 MoReg 2235		26 MoReg 62
5 CSR 90-4.120	Vocational Rehabilitation		This Issue		
5 CSR 90-5.400	Vocational Rehabilitation		This Issue		
5 CSR 90-5.440	Vocational Rehabilitation		This Issue		
	DEPARTMENT OF HIGHER EDUCATION				
6 CSR 10-2.030	Commissioner of Higher Education		25 MoReg 2796		
6 CSR 10-5.010	Commissioner of Higher Education		25 MoReg 2796R 25 MoReg 2796		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-1.010	Highways and Transportation Commission		25 MoReg 1830R 25 MoReg 1830		25 MoReg 2908R 25 MoReg 2908
7 CSR 10-10.010	Highways and Transportation Commission	26 MoReg 5	26 MoReg 39		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
7 CSR 10-10.030	Highways and Transportation Commission	26 MoReg 6	26 MoReg 40		
7 CSR 10-10.040	Highways and Transportation Commission	26 MoReg 7	26 MoReg 41		
7 CSR 10-10.050	Highways and Transportation Commission	26 MoReg 8	26 MoReg 41		
7 CSR 10-10.060	Highways and Transportation Commission	26 MoReg 8	26 MoReg 45		
7 CSR 10-10.070	Highways and Transportation Commission	26 MoReg 9	26 MoReg 45		
7 CSR 10-10.080	Highways and Transportation Commission	26 MoReg 10	26 MoReg 46		
7 CSR 10-10.090	Highways and Transportation Commission	26 MoReg 11	26 MoReg 46		
7 CSR 10-14.010	Highways and Transportation Commission		25 MoReg 635		
			25 MoReg 2097	25 MoReg 2910	
7 CSR 10-14.020	Highways and Transportation Commission	25 MoReg 629	25 MoReg 639		
			25 MoReg 2100	25 MoReg 2910	
7 CSR 10-14.030	Highways and Transportation Commission	25 MoReg 629	25 MoReg 639		
			25 MoReg 2100	25 MoReg 2911	
7 CSR 10-14.040	Highways and Transportation Commission	25 MoReg 630	25 MoReg 640		
			25 MoReg 2101	25 MoReg 2911	
7 CSR 10-14.050	Highways and Transportation Commission		25 MoReg 640		
		25 MoReg 2045	25 MoReg 2102	25 MoReg 2911	
7 CSR 10-14.060	Highways and Transportation Commission		25 MoReg 641		
			25 MoReg 2102	25 MoReg 2911	
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 5-1.010	Administration		25 MoReg 2103R		
8 CSR 30-3.010	Division of Labor Standards		25 MoReg 2877		
8 CSR 50-7.050	Workers' Compensation		25 MoReg 1698	25 MoReg 2834	
8 CSR 50-7.060	Workers' Compensation		25 MoReg 1698	25 MoReg 2834	
8 CSR 50-7.070	Workers' Compensation		25 MoReg 1698	25 MoReg 2834	
8 CSR 70-1.010	MO Assistive Technology Advisory Council	25 MoReg 2191	25 MoReg 2237	25 MoReg 2911	
	DEPARTMENT OF MENTAL HEALTH				
9 CSR 25-2.105	Fiscal Management		25 MoReg 2805		
9 CSR 25-2.305	Fiscal Management		25 MoReg 2806		
9 CSR 30-4.042	Certification Standards	25 MoReg 1955	25 MoReg 1961	25 MoReg 2834	
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-2.030	Air Conservation Commission		25 MoReg 2292R		
10 CSR 10-2.205	Air Conservation Commission		25 MoReg 2292		
10 CSR 10-2.215	Air Conservation Commission		25 MoReg 2298R		
			25 MoReg 2408		
10 CSR 10-2.260	Air Conservation Commission		26 MoReg 47		
10 CSR 10-2.330	Air Conservation Commission		25 MoReg 2640		
10 CSR 10-3.050	Air Conservation Commission		25 MoReg 2298R		
10 CSR 10-4.030	Air Conservation Commission		25 MoReg 2298R		
10 CSR 10-5.050	Air Conservation Commission		25 MoReg 2298R		
10 CSR 10-5.330	Air Conservation Commission		25 MoReg 1698	25 MoReg 2835	
10 CSR 10-5.375	Air Conservation Commission		25 MoReg 2299		
10 CSR 10-6.040	Air Conservation Commission		25 MoReg 2716		
10 CSR 10-6.120	Air Conservation Commission		25 MoReg 2303		
10 CSR 10-6.200	Air Conservation Commission		25 MoReg 2717		
10 CSR 20-6.011	Clean Water Commission		25 MoReg 2878		
10 CSR 20-6.060	Clean Water Commission		25 MoReg 2880		
10 CSR 20-14.010	Clean Water Commission		25 MoReg 2881		
10 CSR 20-14.020	Clean Water Commission		25 MoReg 2883		
10 CSR 20-14.030	Clean Water Commission		25 MoReg 2885		
10 CSR 25	Hazardous Waste Management Commission				25 MoReg 2597RUC
10 CSR 25-12.010	Hazardous Waste Management Commission				25 MoReg 2253
10 CSR 40-10.010	Land Reclamation Commission		25 MoReg 1623		
10 CSR 40-10.020	Land Reclamation Commission		25 MoReg 1623		
10 CSR 40-10.040	Land Reclamation Commission		25 MoReg 1627		
10 CSR 40-10.100	Land Reclamation Commission		25 MoReg 1627		
10 CSR 60-14.010	Public Drinking Water Program		25 MoReg 2886		
10 CSR 60-14.020	Public Drinking Water Program		25 MoReg 2889		
10 CSR 60-14.030	Public Drinking Water Program		25 MoReg 2899		
10 CSR 90-2.010	Parks, Recreation and Historic Preservation		25 MoReg 2806R		
			25 MoReg 2806		
10 CSR 90-2.020	Parks, Recreation and Historic Preservation		25 MoReg 2810R		
			25 MoReg 2810		
10 CSR 90-2.030	Parks, Recreation and Historic Preservation		25 MoReg 2815R		
			25 MoReg 2815		
10 CSR 90-2.040	State Parks		25 MoReg 2820		
10 CSR 90-2.050	Parks, Recreation and Historic Preservation		25 MoReg 2821R		
			25 MoReg 2821		
10 CSR 90-2.060	Parks, Recreation and Historic Preservation		25 MoReg 2822R		
			25 MoReg 2822		
10 CSR 90-2.070	State Parks		25 MoReg 2824		
10 CSR 140-2	Division of Energy				24 MoReg 2243
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 10-1.010	Adjutant General		25 MoReg 2239	25 MoReg 2911	
11 CSR 10-1.020	Adjutant General		25 MoReg 2528		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
11 CSR 10-3.015	Adjutant General	25 MoReg 2193	25 MoReg 2239	25 MoReg 2912	
11 CSR 10-5.010	Adjutant General		25 MoReg 2528		
11 CSR 10-5.015	Adjutant General		25 MoReg 2531		
11 CSR 40-5.040	Division of Fire Safety		25 MoReg 2411	This Issue	
11 CSR 40-5.050	Division of Fire Safety		25 MoReg 2411	This Issue	
11 CSR 40-5.065	Division of Fire Safety		25 MoReg 2411	This Issue	
11 CSR 40-5.090	Division of Fire Safety		25 MoReg 2412	This Issue	
11 CSR 40-5.120	Division of Fire Safety	25 MoReg 2283	25 MoReg 2412	This Issue	
11 CSR 45-4.380	Missouri Gaming Commission	25 MoReg 2713	25 MoReg 2717		
11 CSR 45-4.390	Missouri Gaming Commission		25 MoReg 1631	25 MoReg 2577	
		25 MoReg 2713	25 MoReg 2718		
11 CSR 45-5.183	Missouri Gaming Commission		25 MoReg 2103	26 MoReg 63	
11 CSR 45-10.110	Missouri Gaming Commission	25 MoReg 2714	25 MoReg 2718		
11 CSR 45-11.110	Missouri Gaming Commission	25 MoReg 1679	25 MoReg 1702	25 MoReg 2912	
11 CSR 45-17.015	Missouri Gaming Commission		25 MoReg 2719		
11 CSR 45-30.600	Missouri Gaming Commission		25 MoReg 2719		
11 CSR 45-31.005	Missouri Gaming Commission		25 MoReg 2722		
11 CSR 50-2.200	Missouri State Highway Patrol		25 MoReg 2531		
11 CSR 50-2.270	Missouri State Highway Patrol		25 MoReg 2531		
11 CSR 50-2.320	Missouri State Highway Patrol		25 MoReg 2532		
11 CSR 50-2.330	Missouri State Highway Patrol		25 MoReg 2532		
11 CSR 75-3.020	Peace Officer Standards and Training		25 MoReg 2827		
11 CSR 75-3.030	Peace Officer Standards and Training		25 MoReg 2645		
11 CSR 75-11.010	Peace Officer Standards and Training		25 MoReg 2307	26 MoReg 63	
11 CSR 75-11.020	Peace Officer Standards and Training		25 MoReg 2307	26 MoReg 63	
11 CSR 75-11.030	Peace Officer Standards and Training		25 MoReg 2308	26 MoReg 63	
11 CSR 75-11.040	Peace Officer Standards and Training		25 MoReg 2309R	26 MoReg 63R	
11 CSR 75-11.070	Peace Officer Standards and Training		25 MoReg 2309	26 MoReg 64	
	DEPARTMENT OF REVENUE				
12 CSR	Construction Transient Employers				25 MoReg 1490
					25 MoReg 2147
					25 MoReg 2747
12 CSR 10-3.028	Director of Revenue		25 MoReg 2646R		
12 CSR 10-3.030	Director of Revenue		25 MoReg 2646R		
12 CSR 10-3.032	Director of Revenue		25 MoReg 2647R		
12 CSR 10-3.054	Director of Revenue		25 MoReg 2722R		
12 CSR 10-3.058	Director of Revenue		25 MoReg 2722R		
12 CSR 10-3.062	Director of Revenue		25 MoReg 2722R		
12 CSR 10-3.064	Director of Revenue		25 MoReg 2723R		
12 CSR 10-3.070	Director of Revenue		25 MoReg 2723R		
12 CSR 10-3.072	Director of Revenue		25 MoReg 2723R		
12 CSR 10-3.074	Director of Revenue		25 MoReg 2723R		
12 CSR 10-3.078	Director of Revenue		25 MoReg 2724R		
12 CSR 10-3.080	Director of Revenue		25 MoReg 2724R		
12 CSR 10-3.082	Director of Revenue		25 MoReg 2724R		
12 CSR 10-3.084	Director of Revenue		25 MoReg 2724R		
12 CSR 10-3.090	Director of Revenue		25 MoReg 2725R		
12 CSR 10-3.102	Director of Revenue		25 MoReg 2647R		
12 CSR 10-3.131	Director of Revenue		25 MoReg 2414R	This IssueR	
12 CSR 10-3.152	Director of Revenue		25 MoReg 2725R		
12 CSR 10-3.154	Director of Revenue		25 MoReg 2725R		
12 CSR 10-3.156	Director of Revenue		25 MoReg 2725R		
12 CSR 10-3.162	Director of Revenue		25 MoReg 2726R		
12 CSR 10-3.167	Director of Revenue		25 MoReg 2902R		
12 CSR 10-3.186	Director of Revenue		25 MoReg 2726R		
12 CSR 10-3.210	Director of Revenue		25 MoReg 2414R	This IssueR	
12 CSR 10-3.212	Director of Revenue		25 MoReg 2647R		
12 CSR 10-3.214	Director of Revenue		25 MoReg 2647R		
12 CSR 10-3.216	Director of Revenue		25 MoReg 2648R		
12 CSR 10-3.218	Director of Revenue		25 MoReg 2648R		
12 CSR 10-3.220	Director of Revenue		25 MoReg 2648R		
12 CSR 10-3.460	Director of Revenue	25 MoReg 144			
12 CSR 10-3.471	Director of Revenue		25 MoReg 2726R		
12 CSR 10-3.472	Director of Revenue		25 MoReg 2648R		
12 CSR 10-3.474	Director of Revenue		25 MoReg 2649R		
12 CSR 10-3.476	Director of Revenue		25 MoReg 2649R		
12 CSR 10-3.478	Director of Revenue		25 MoReg 2649R		
12 CSR 10-3.479	Director of Revenue		25 MoReg 2649R		
12 CSR 10-3.524	Director of Revenue		25 MoReg 2902R		
12 CSR 10-3.588	Director of Revenue		25 MoReg 2902R		
12 CSR 10-3.840	Director of Revenue		25 MoReg 2726R		
12 CSR 10-3.842	Director of Revenue		25 MoReg 2650R		
12 CSR 10-3.844	Director of Revenue		25 MoReg 2650R		
12 CSR 10-3.878	Director of Revenue		25 MoReg 2650R		
12 CSR 10-3.898	Director of Revenue		25 MoReg 2650R		
12 CSR 10-4.070	Director of Revenue		25 MoReg 2650R		
12 CSR 10-4.075	Director of Revenue		25 MoReg 2651R		
12 CSR 10-4.165	Director of Revenue		25 MoReg 2902R		
12 CSR 10-4.624	Director of Revenue		25 MoReg 2414R	This IssueR	
12 CSR 10-4.632	Director of Revenue		25 MoReg 2651R		
12 CSR 10-4.634	Director of Revenue		25 MoReg 2726R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
12 CSR 10-5.010	Director of Revenue		25 MoReg 2727R		
12 CSR 10-24.402	Director of Revenue		25 MoReg 2727R		
12 CSR 10-25.050	Director of Revenue		25 MoReg 2415	This Issue	
12 CSR 10-25.130	Director of Revenue		25 MoReg 2420	This Issue	
12 CSR 10-25.140	Director of Revenue		25 MoReg 2420	This Issue	
12 CSR 10-25.150	Director of Revenue		25 MoReg 2420	This Issue	
12 CSR 10-41.010	Director of Revenue	25 MoReg 2787	25 MoReg 2827		
12 CSR 10-101.600	Director of Revenue		25 MoReg 2902		
12 CSR 10-102.016	Director of Revenue *(Changed from 12 CSR 10-110.016)*				25 MoReg 2914
12 CSR 10-102.100	Director of Revenue *(Changed from 12 CSR 10-115.100)*				25 MoReg 2914
12 CSR 10-103.220	Director of Revenue		25 MoReg 2651R		
12 CSR 10-103.250	Director of Revenue		25 MoReg 2903		
12 CSR 10-103.555	Director of Revenue		25 MoReg 2421	This Issue	
12 CSR 10-103.560	Director of Revenue		25 MoReg 2241	25 MoReg 2912	
12 CSR 10-103.600	Director of Revenue		25 MoReg 1833	25 MoReg 2835	
12 CSR 10-103.700	Director of Revenue		25 MoReg 2422		
12 CSR 10-103.800	Director of Revenue		25 MoReg 2422	This Issue	
12 CSR 10-110.016	Director of Revenue *(Changed to 12 CSR 10-102.016)*				25 MoReg 2914
12 CSR 10-110.200	Director of Revenue		25 MoReg 2423		
12 CSR 10-110.950	Director of Revenue		25 MoReg 2242	25 MoReg 2912	
12 CSR 10-110.990	Director of Revenue		25 MoReg 1966	25 MoReg 2912	
12 CSR 10-115.100	Director of Revenue *(Changed to 12 CSR 10-102.100)*				25 MoReg 2914
12 CSR 30-3.025	State Tax Commission		25 MoReg 2242	This Issue	
12 CSR 30-3.075	State Tax Commission		25 MoReg 2827		
12 CSR 40-20.030	State Lottery		25 MoReg 2424		
12 CSR 40-40.230	State Lottery		25 MoReg 2424		
12 CSR 40-40.250	State Lottery		25 MoReg 2424		
12 CSR 40-60.010	State Lottery		25 MoReg 2425		
12 CSR 40-60.030	State Lottery		25 MoReg 2425		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 15-4.010	Division of Aging		25 MoReg 2425		
13 CSR 15-4.040	Division of Aging		25 MoReg 2427		
13 CSR 15-4.080	Division of Aging		25 MoReg 2428		
13 CSR 15-4.090	Division of Aging		25 MoReg 2428		
13 CSR 15-4.100	Division of Aging		25 MoReg 2428		
13 CSR 15-4.105	Division of Aging		25 MoReg 2429		
13 CSR 15-4.135	Division of Aging		25 MoReg 2430		
13 CSR 15-4.140	Division of Aging		25 MoReg 2430		
13 CSR 15-4.150	Division of Aging		25 MoReg 2430		
13 CSR 15-4.160	Division of Aging		25 MoReg 2431		
13 CSR 15-4.170	Division of Aging		25 MoReg 2431		
13 CSR 15-4.175	Division of Aging		25 MoReg 2432		
13 CSR 15-4.190	Division of Aging		25 MoReg 2432		
13 CSR 15-4.200	Division of Aging		25 MoReg 2432		
13 CSR 15-4.230	Division of Aging		25 MoReg 2433		
13 CSR 15-4.270	Division of Aging		25 MoReg 2434		
13 CSR 15-4.290	Division of Aging		25 MoReg 2434		
13 CSR 15-4.300	Division of Aging		25 MoReg 2434		
13 CSR 15-4.310	Division of Aging		25 MoReg 2435		
13 CSR 15-7.010	Division of Aging		25 MoReg 2435		
13 CSR 15-7.040	Division of Aging		25 MoReg 2436		
13 CSR 15-7.050	Division of Aging		25 MoReg 2438		
13 CSR 15-9.010	Division of Aging		26 MoReg 53		
13 CSR 15-15.045	Division of Aging	This Issue	This Issue		
13 CSR 30-5.010	Child Support Enforcement		25 MoReg 1840R 25 MoReg 2904R		
13 CSR 40-19.020	Division of Family Services	25 MoReg 2365	25 MoReg 2439	This Issue	
13 CSR 40-31.050	Division of Family Services	This IssueR	This IssueR		
13 CSR 40-32.020	Division of Family Services	This Issue	This Issue		
13 CSR 40-91.030	Division of Family Services		25 MoReg 2309	This Issue	
13 CSR 45-2.010	Division of Legal Services	This Issue	This Issue		
13 CSR 70-3.020	Medical Services		25 MoReg 2441		
13 CSR 70-10.015	Medical Services	25 MoReg 2196	25 MoReg 1967 25 MoReg 2728	26 MoReg 64	
13 CSR 70-10.030	Medical Services		25 MoReg 2532		
13 CSR 70-10.050	Medical Services	25 MoReg 2198	25 MoReg 1971	26 MoReg 67	
13 CSR 70-10.080	Medical Services	25 MoReg 2198	25 MoReg 1973	26 MoReg 68	
13 CSR 70-10.150	Medical Services	25 MoReg 2869	25 MoReg 2904		
13 CSR 70-20.031	Medical Services	25 MoReg 2870	25 MoReg 1976	26 MoReg 69	
13 CSR 70-20.032	Medical Services		25 MoReg 1976	26 MoReg 69	
13 CSR 70-20.034	Medical Services	25 MoReg 2870	25 MoReg 1977	26 MoReg 70	
13 CSR 70-20.045	Medical Services	25 MoReg 2871	25 MoReg 1978 This Issue	26 MoReg 70	
13 CSR 70-20.050	Medical Services		This Issue		
13 CSR 70-20.070	Medical Services		This Issue		
13 CSR 70-91.010	Medical Services		This Issue		
13 CSR 73-2.051	Missouri Board of Nursing Home Administrators		25 MoReg 2828		
	ELECTED OFFICIALS				
15 CSR 30-4.010	Secretary of State	25 MoReg 2509	25 MoReg 2535		
15 CSR 30-45.040	Secretary of State	This Issue	25 MoReg 2728		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
15 CSR 40-3.100	State Auditor	25 MoReg 2045R	25 MoReg 2103R	This IssueR	
15 CSR 40-3.110	State Auditor	25 MoReg 2046R	25 MoReg 2104R	This IssueR	
15 CSR 40-3.120	State Auditor	25 MoReg 2046	25 MoReg 2104	This Issue	
15 CSR 60-10.010	Attorney General	25 MoReg 2285	25 MoReg 2312		
15 CSR 60-10.020	Attorney General	25 MoReg 2285	25 MoReg 2312		
15 CSR 60-10.030	Attorney General	25 MoReg 2287	25 MoReg 2313		
15 CSR 60-13.010	Attorney General		25 MoReg 2538		
15 CSR 60-13.020	Attorney General		25 MoReg 2538		
15 CSR 60-13.030	Attorney General		25 MoReg 2542		
15 CSR 60-13.040	Attorney General		25 MoReg 2545		
15 CSR 60-13.050	Attorney General		25 MoReg 2545		
15 CSR 60-13.060	Attorney General		25 MoReg 2545		
15 CSR 60-13.070	Attorney General		25 MoReg 2552		
	RETIREMENT SYSTEMS				
16 CSR 10-4.014	The Public School Retirement System of Missouri		25 MoReg 2442	This Issue	
16 CSR 10-5.055	The Public School Retirement System of Missouri		25 MoReg 2443	This Issue	
16 CSR 10-5.030	The Public School Retirement System of Missouri		This Issue		
16 CSR 10-6.045	The Public School Retirement System of Missouri		25 MoReg 2832		
16 CSR 10-6.060	The Public School Retirement System of Missouri		25 MoReg 2443	This Issue	
16 CSR 10-6.090	The Public School Retirement System of Missouri		This Issue		
16 CSR 20-2.060	Missouri Local Government Employees' Retirement System (LAGERS)		25 MoReg 2445	This Issue	
16 CSR 20-3.010	Missouri Local Government Employees' Retirement System (LAGERS)		25 MoReg 2445	This Issue	
16 CSR 50-1.010	The County Employees' Retirement Fund		25 MoReg 2652		
16 CSR 50-1.020	The County Employees' Retirement Fund		25 MoReg 2653		
16 CSR 50-1.030	The County Employees' Retirement Fund		25 MoReg 2653		
16 CSR 50-2.010	The County Employees' Retirement Fund		25 MoReg 2653R 25 MoReg 2653		
16 CSR 50-2.020	The County Employees' Retirement Fund		25 MoReg 2655R 25 MoReg 2656		
16 CSR 50-2.030	The County Employees' Retirement Fund		25 MoReg 2656R 25 MoReg 2656		
16 CSR 50-2.035	The County Employees' Retirement Fund		25 MoReg 2657R 25 MoReg 2657		
16 CSR 50-2.040	The County Employees' Retirement Fund		25 MoReg 2659R 25 MoReg 2659		
16 CSR 50-2.050	The County Employees' Retirement Fund		25 MoReg 2659R 25 MoReg 2660		
16 CSR 50-2.060	The County Employees' Retirement Fund		25 MoReg 2660R		
16 CSR 50-2.080	The County Employees' Retirement Fund		25 MoReg 2660		
16 CSR 50-2.090	The County Employees' Retirement Fund		25 MoReg 2661		
16 CSR 50-2.100	The County Employees' Retirement Fund		25 MoReg 2662		
16 CSR 50-2.110	The County Employees' Retirement Fund		25 MoReg 2662		
16 CSR 50-2.120	The County Employees' Retirement Fund		25 MoReg 2662		
16 CSR 50-2.130	The County Employees' Retirement Fund		25 MoReg 2663		
16 CSR 50-2.140	The County Employees' Retirement Fund		25 MoReg 2664		
16 CSR 50-2.150	The County Employees' Retirement Fund		25 MoReg 2664		
16 CSR 50-2.160	The County Employees' Retirement Fund		25 MoReg 2666		
16 CSR 50-3.010	The County Employees' Retirement Fund		25 MoReg 2666R 25 MoReg 2666		
16 CSR 50-3.020	The County Employees' Retirement Fund		25 MoReg 2667R		
16 CSR 50-3.030	The County Employees' Retirement Fund		25 MoReg 2667R		
16 CSR 50-3.040	The County Employees' Retirement Fund		25 MoReg 2668R		
16 CSR 50-3.050	The County Employees' Retirement Fund		25 MoReg 2668R		
16 CSR 50-3.060	The County Employees' Retirement Fund		25 MoReg 2668		
16 CSR 50-3.070	The County Employees' Retirement Fund		25 MoReg 2669		
16 CSR 50-3.080	The County Employees' Retirement Fund		25 MoReg 2669R		
16 CSR 50-3.090	The County Employees' Retirement Fund		25 MoReg 2669R		
16 CSR 50-10.010	The County Employees' Retirement Fund		25 MoReg 1714	25 MoReg 2835	
16 CSR 50-10.020	The County Employees' Retirement Fund		25 MoReg 1715	25 MoReg 2835	
16 CSR 50-10.030	The County Employees' Retirement Fund		25 MoReg 1716	25 MoReg 2835	
16 CSR 50-10.040	The County Employees' Retirement Fund		25 MoReg 1717	25 MoReg 2836	
16 CSR 50-10.050	The County Employees' Retirement Fund		25 MoReg 1717	25 MoReg 2836	
16 CSR 50-10.060	The County Employees' Retirement Fund		25 MoReg 1718	25 MoReg 2837	
16 CSR 50-10.070	The County Employees' Retirement Fund		25 MoReg 1719	25 MoReg 2837	
16 CSR 50-10.080	The County Employees' Retirement Fund		25 MoReg 1719	25 MoReg 2837	
16 CSR 50-10.090	The County Employees' Retirement Fund		25 MoReg 1720	25 MoReg 2837	
16 CSR 50-20.010	The County Employees' Retirement Fund		25 MoReg 1720	25 MoReg 2837	
16 CSR 50-20.020	The County Employees' Retirement Fund		25 MoReg 1721	25 MoReg 2837	
16 CSR 50-20.030	The County Employees' Retirement Fund		25 MoReg 1722	25 MoReg 2838	
16 CSR 50-20.050	The County Employees' Retirement Fund		25 MoReg 1722	25 MoReg 2838	
16 CSR 50-20.060	The County Employees' Retirement Fund		25 MoReg 1723	25 MoReg 2838	
16 CSR 50-20.070	The County Employees' Retirement Fund		25 MoReg 1723	25 MoReg 2838	
16 CSR 50-20.080	The County Employees' Retirement Fund		25 MoReg 1724	25 MoReg 2839	
16 CSR 50-20.090	The County Employees' Retirement Fund		25 MoReg 1724	25 MoReg 2839	
16 CSR 50-20.100	The County Employees' Retirement Fund		25 MoReg 1725	25 MoReg 2839	
16 CSR 50-20.110	The County Employees' Retirement Fund		25 MoReg 1725	25 MoReg 2839	
	DEPARTMENT OF HEALTH				
19 CSR 10-4.020	Office of the Director	25 MoReg 2512	25 MoReg 2552	This Issue	
19 CSR 10-5.010	Office of the Director		25 MoReg 2554		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 20-20.080	Division of Environmental Health and Communicable Disease Prevention	25 MoReg 1683R	25 MoReg 1738R	25 MoReg 2839R	
19 CSR 30-24.020	Division of Health Standards and Licensure		25 MoReg 1851	25 MOReg 2913	
19 CSR 30-40.302	Division of Health Standards and Licensure		26 MoReg 56		
19 CSR 30-80.010	Division of Health Standards and Licensure	25 MoReg 2629	25 MoReg 2669		
19 CSR 30-80.020	Division of Health Standards and Licensure	25 MoReg 2629	25 MoReg 2670		
19 CSR 30-80.030	Division of Health Standards and Licensure	25 MoReg 2630	25 MoReg 2670		
19 CSR 30-80.040	Division of Health Standards and Licensure	25 MoReg 2631	25 MoReg 2675		
19 CSR 60-50.300	Missouri Health Facilities Review		25 MoReg 206	25 MoReg 1647	
19 CSR 60-50.420	Missouri Health Facilities Review				25 MoReg 1796 25 MoReg 2013 25 MoReg 2254 25 MoReg 2477 25 MoReg 2599 25 MoReg 2745 25 MoReg 2914 This Issue
19 CSR 60-50.470	Missouri Health Facilities Review		25 MoReg 207		
	DEPARTMENT OF INSURANCE				
20 CSR	Medical Malpractice				23 MoReg 514 24 MoReg 682 25 MoReg 597
	Sovereign Immunity Limits				25 MoReg 724 26 MoReg 75
20 CSR 10-1.020	General Administration		This Issue		
20 CSR 200-1.020	Financial Examination		This Issue		
20 CSR 200-1.040	Financial Examination		This Issue		
20 CSR 200-1.050	Financial Examination		This Issue		
20 CSR 200-1.110	Financial Examination		This Issue		
20 CSR 200-1.140	Financial Examination		This Issue		
20 CSR 400-7.180	Life, Annuities and Health		25 MoReg 1895	26 MoReg 70	
20 CSR 500-6.700	Property and Casualty		25 MoReg 2446		
20 CSR 500-10.100	Property and Casualty		25 MoReg 2459		
20 CSR 500-10.200	Property and Casualty		This Issue		
20 CSR 500-10.300	Property and Casualty		25 MoReg 2459		
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.020	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.040	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.050	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.060	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.063	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.064	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.065	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.067	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.070	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.075	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.080	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		

Emergency Rules in Effect as of January 16, 2001

Expires

Office of Administration

Commissioner of Administration

1 CSR 10-15.010 Cafeteria Plan . . . . . June 29, 2001

Department of Agriculture

Division of Animal Health

2 CSR 30-10.010 Inspection of Meat and Poultry . . . . . April 1, 2001

Department of Economic Development

State Board of Nursing

4 CSR 200-4.010 Fees . . . . . June 29, 2001

Division of Motor Carrier and Railroad Safety

4 CSR 265-10.030 Insurance . . . . . June 30, 2001

Department of Transportation

Missouri Highways and Transportation Commission

7 CSR 10-10.010 Definitions . . . . . June 29, 2001
7 CSR 10-10.030 Rating Categories for Evaluating the Performance of a Contractor . . . . . June 29, 2001
7 CSR 10-10.040 Contractor Performance Questionnaire Used in Evaluating Contractor Performance . . . . . June 29, 2001
7 CSR 10-10.050 Procedure and Schedule for Completing the Contractor Performance Questionnaire . . . . . June 29, 2001
7 CSR 10-10.060 Explanation of Standard Deviation Rating System for all Contractors . . . . . June 29, 2001
7 CSR 10-10.070 Procedure for Annual Rating of Contractors . . . . . June 29, 2001
7 CSR 10-10.080 Determination of Nonresponsibility . . . . . June 29, 2001
7 CSR 10-10.090 Reservation of Rights to Recommend or Declare Persons or Contractors Nonresponsible on Other Grounds . . . . . June 29, 2001

Department of Labor and Industrial Relations

Missouri Assistive Technology Advisory Council

8 CSR 70-1.010 Telecommunications Access Program . . . . . February 23, 2001

Department of Mental Health

Certification Standards

9 CSR 30-4.042 Admission Criteria . . . . . February 22, 2001

Department of Public Safety

Adjutant General

11 CSR 10-3.015 State Sponsored Missouri National Guard Member Educational Assistance Program . . . . February 23, 2001

Division of Fire Safety

11 CSR 40-5.120 Inspectors . . . . . March 2, 2001

Missouri Gaming Commission

11 CSR 45-4.380 Occupational License Application and Annual Fees . . . . . April 11, 2001
11 CSR 45-4.390 Occupational License Renewal . . . . . April 11, 2001
11 CSR 45-10.110 Licensee's Duty to Report Occupational Personnel . . . . . April 11, 2001
11 CSR 45-11.110 Refund—Claim for Refund . . . . . February 22, 2001

Department of Revenue

Director of Revenue

12 CSR 10-41.010 Adjusted Rate of Interest . . . . . June 29, 2001

Department of Social Services

Division of Aging

13 CSR 15-10.070 Alzheimer's Demonstration Projects . . . . . February 1, 2001
13 CSR 15-15.045 Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia . . . . . June 30, 2001

Division of Family Services

13 CSR 40-19.020 Low Income Home Energy Assistance Program . . . . . March 28, 2001
13 CSR 40-31.050 Child Fatality Review Process . . . . . June 29, 2001
13 CSR 40-32.020 Processing of Applications for State and Federal Funds for Providing Child Care Services . . . June 29, 2001

Legal Services

13 CSR 45-2.010 Organization and Operation . . . . . June 29, 2001

Division of Medical Services

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services . . . . . January 24, 2001
13 CSR 70-10.050 Pediatric Nursing Care Plan . . . . . January 24, 2001

Elected Officials

Department of Health

Missouri Consolidated Health Care Plan

The rule number and the MoReg publication date follow each entry to this index.

TAX, STATE USE

TELEPHONE EQUIPMENT PROGRAM

TRANSPORTATION, DISADVANTAGED BUSINESS ENTERPRISE PROGRAM

UNEMPLOYMENT INSURANCE

VETERINARY MEDICAL BOARD, MISSOURI

VOTERS

WEIGHTS AND MEASURES

WORKERS' COMPENSATION

WORKFORCE DEVELOPMENT

The *official* source of information on Missouri state regulations

PUBLISHED SEMI-MONTHLY — 56^{00} PER YEAR

ORDER FORM

☐ **Enclosed is my check for $56 as payment in advance for one year of the *Missouri Register***

Please start my subscription with the _____ issue.

☐ **Enclosed is my check for $330 for the *Code of State Regulations***

☐ **This is a subscription renewal**

Please make checks payable to: **Director of Revenue**

Mail to: **Matt Blunt**
Secretary of State
Administrative Rules Division
P.O. Box 1767
Jefferson City, MO 65102

_____
name or firm (please type or print) **attn:**

_____
P.O. box number

_____
street address **city** **state** **zip**

BEFORE YOU MOVE

. . . please let us know!

To be sure that you do not miss any issues of your ***Missouri Register*** subscription, please notify us at least four weeks before you move to your new address.

1. Present address
   Attach address label from a recent issue, or print name and address exactly as shown on the label.

_____
Name

_____
Address

_____
City State Zip

2. Fill in new address

_____
Name

_____
Address

_____
City State Zip

01/16/01

Matt Blunt
Secretary of State
P.O. Box 1767
Jefferson City, MO 65102

Periodical
Postage Paid at
Jefferson City,
MO